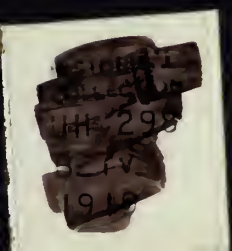
A VISION OF THE POSSIBLE

WHAT THE R.A.M.C. MIGHT BECOME

JAMES W. BARRETT



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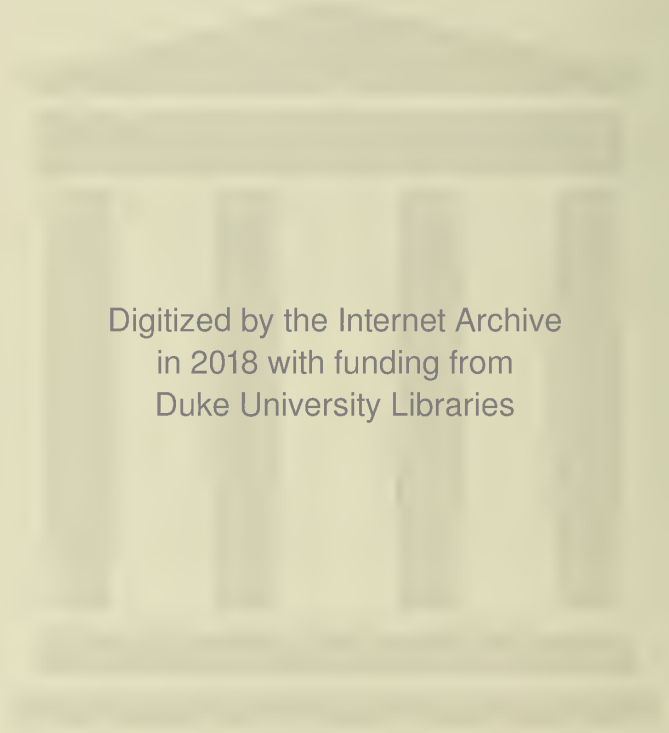

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PREFACE

I HAVE ventured in the following pages to set down some of the conclusions formed by me after service in the R.A.M.C. during three years of war. I had previously had nearly one year's experience in the Australian Army Medical Corps in Egypt, *i.e.* a service which represents a loose replica of the arrangements and methods of the R.A.M.C. My experience of the R.A.M.C., and contact with its traditions and with its regular officers, have been very interesting and instructive. I am leaving the service, however, with the conviction that if its traditions are to be maintained, and if it is to develop into the service it should be—a service of which any nation may be proud—some of its archaic methods must be modified; modern methods must be introduced and provision made for greater flexibility. It is undesirable to a degree that any great institution should progress by mutations, it should be so constructed and balanced that it responds almost automatically to development in science, to improvements in methods, and indeed to the spirit of the time. Change by mutation implies abrupt alterations with their inconveniences, their hardships, their controversies, and all that such things connote.

I have tried to set out plainly some account of my own experience in connection with the service. I have endeavoured to indicate its source of strength, and I have also, with equal plainness, sought to indicate its shortcomings.

The reader may ask why at the end of a successful war, where the sick and the wounded have, on the whole, been well attended to, should it be necessary to deal with the subject in this critical fashion; such readers may be reminded of the Mesopotamian Commission, of the Dardanelles Commission, and of the appalling damage done by venereal disease. The criticisms do not for one moment imply that men who were actually sick were not looked after as well as they could be in the circumstances, but it is quite possible that had arrangements been better the circumstances might have been very different, that neither of these commissions need have been appointed, and there might have been no venereal cases to deal with.

It is quite certain that Great Britain and the Empire will require an army in the future, and it is quite as certain that a highly trained and efficient R.A.M.C. will be necessary. How is it to be recruited? If there is one attitude more characteristic than another of some of the distinguished civilian medical practitioners who have served in Egypt during the past three years, it is that they will not recommend any young men who mean to take medicine seriously to join the R.A.M.C. as it is at present constituted. As one of them put it, any decent young man who wants to live in different parts of the world, who is fond of hunting, riding, fishing, and shooting, and who is prepared to do a fair day's work, may be recommended to join the R.A.M.C. Those who mean to make medicine and surgery the preoccupation of their lives had better stay out of it. Be it remembered too that this statement was made by a distinguished surgeon who had previously been recommending his pupils to join.

The nation cannot contemplate such an attitude

with indifference, and I am convinced that national action will be necessary to effect the changes needed, and to convert an honest but somewhat mediocre service into an organization of the first order and efficiency properly endowed with scientific imagination.

Is it not clear that an Army Medical Service should lead the world in scientific medicine? The conditions are ideal, since men are provided with fair salaries and a guarantee against want in the form of a pension; they have abundant leisure, they have hospitals and laboratories at their disposal, and the patients are under discipline. Can any human being imagine conditions better fitted for the development of a thorough knowledge of medicine, both on its curative and on its preventive side? There should be simply no limitation to the nature of the problems they can attack, and such a service should easily lead the world. What a contrast employment in such a service offers to that of the struggling surgeon or consultant, borne down by the drudgery of having to seek for a living, provided with insufficient instruments, dependent for improvement on the increase of his patients, and always with the fear of a poverty-stricken old age in front of him! Yet what has the R.A.M.C. done? I do not overlook certain brilliant and individual instances of development, but in the main what has been the scientific output from the R.A.M.C. compared with that from any similar group of privileged medical men? The best test to apply to the result is to ask oneself how many medical practitioners not members of the military service ever think of turning to the R.A.M.C. for guidance. It is our business in the following pages to try to show why this relative failure has occurred. The matter is of great importance, since

it is quite certain that any service of State medicine will fail to produce the finest results unless different principles of administration are introduced.

Of the organization of the R.A.M.C. before the war I know little, and nothing of first-hand knowledge. Of its organization and administration in other theatres of war I possess only second-hand information, but positive knowledge has been gained through a four years' experience in one theatre of war, Egypt, and through some little acquaintance with the Head-quarters in London. Owing to the position occupied by me as Consulting Aurist Egyptian Expeditionary Force (E.E.F.), and as President of a Standing Medical Board, a wide survey over the field in Egypt has been obtained. Furthermore, the Egyptian theatre has offered singular facilities for weighing the advantages and disadvantages of the system, by reason of the fact that it was self-contained, and that it was consequently easy to ascertain and note details anywhere from the fighting line to the seaports. The statements contained in this work are therefore concerned only with what has occurred in Egypt during the four years of war, and represent my own personal impressions.

In addition to purely military work, I occupied other offices. In 1914 I was first secretary to the Australian Branch of the British Red Cross in Australia, and in 1915 Executive Officer to the British Red Cross, Australian Branch, in Egypt. I became a member of the Cairo Council of the British Red Cross Society in Egypt and also a member of the War Work Committee of the Y.M.C.A. During the four years of the war I have practically acted as a *liaison* officer between the Y.M.C.A. and the Army Medical Service. My opportunities therefore for obtaining knowledge respecting

the administration of the Army Medical Service have been considerable.

For convenience this volume is divided into five Sections, namely:

Section I, which contains a *résumé* of my personal experience as a Consulting Oculist and Aurist to the Forces in Egypt, and incidentally much information respecting the details of administration in the Army Medical Services.

Section II, which contains an account of the work done by me as President of a Medical Standing Board, and throws even more extensive light on the work of the Medical Services in Egypt.

Section III, which deals with the problem of venereal disease in Egypt.

Section IV, which deals with the relationship of the Red Cross to the Army Medical Service, and

Section V, which contains a series of sympathetic criticisms of the Army Medical Service itself, together with a statement of the methods which appear to me to be most likely to produce a higher order of efficiency.

Dean Inge has pointed out with force that the characteristic British faults are rather intellectual than moral, and that statement I believe to be substantially correct. It is certainly correct in the main so far as the regular R.A.M.C. is concerned. I hope that those who may read that which follows will understand that my criticisms are directed in all instances at the system in which the R.A.M.C. officers are enmeshed and not at the officer himself. It is impossible for anyone, like myself, whose occupation prior to the war was entirely civil to enter into an old service, and come in contact with the finest type of regular soldier, both combatant and medical, without

being impressed with the character of such men. Whatever limitations they may have, limitations largely imposed on them by the conditions under which the nation forces them to work, there is no doubt that it is their character which has saved the nation, and indeed civilization, from complete destruction. No more tragic or terrible story than that of the successful defence of France during 1914 and 1915 can ever be told. These men, ill equipped with the machinery of modern warfare, were compelled to face the most magnificent fighting machine the world has ever seen, and they saved the nation that sent them ill equipped by dying where they stood. The R.A.M.C. officer, no less than the combatant officer, played his part, and I shall be humiliated indeed if anyone who may read the criticisms which follow should imagine for one moment that I have forgotten the service these men have rendered to mankind.

The R.A.M.C. includes a number of regular officers who are as keen professionally as anyone could wish, but who, entangled in the system in which they live, are inarticulate; they cannot write as I am now writing, they cannot speak as I propose to speak; if they did so it is more than likely that their career would not be as comfortable as they desire, and that its duration would be curtailed, for it is not a service that encourages self-criticism, whether written or spoken. By the time such men reach positions in which they are able to put their reforming ideas into practice, they are becoming old, their enthusiasms are colder, their pensions are close at hand, and they cannot afford to risk the disturbances that all radical changes in any great service are bound to cause. Indeed many of them agree with much that follows and would give a great deal to be able to express themselves freely. Would it were

possible that they could do so, because in many instances they would be able to criticize more effectively than I can, by reason of their more intimate knowledge of detail. In order that the matter may not be misunderstood, and that it may not be possible for anyone to imagine that the criticisms that follow are in any way personal, it has been decided to omit all names from the text. The problem does not involve criticism of the conduct of individuals, but of the duties attached to offices.

In conclusion may I emphasize the fact that I am leaving the service with feelings of the most affectionate respect for a number of regular R.A.M.C. officers with whom I have been associated, for their honesty, their courtesy, and for their moral worth, and I only hope that some of them may retain for me a fraction of the regard that I shall ever feel for them.

ERRATA

Page 65, line 6 from bottom, *for* "direct" *read* "directly."

" 88, " 3, *for* "table" *read* "tables."

" 92, Table (*a*). The first column of figures alone refers to Officers; "Hospitals, Convalescent Depots" should be under "Other Ranks."

" 97, line 18, *omit* "in."

" 97, " 23, *after* "gonorrhœal" *add* "clinically."

" 97, " 5 from bottom, *for* "one eye" *read* "three eyes."

" 99, " 6 " " *for* "standard" *read* "standards."

" 102, " 7 " " *in* "a 6/24 vision" *omit* "a."

" 102, " 4 " " *insert* "and" *before* "distances."

" 102, " 3 " " *for* "of" *read* "with."

" 104, " 3 of first par., *for* "can" *read* "should."

" 105, " 6, *omit* "these."

" 117, " 13, *for* "referred to" *read* "described."

" 118, " 18, *for* "again" *read* "once more."

" 131, " 7, *for* "with" *read* "to."

" 140, " 8 from bottom, *for* "these" *read* "the."

" 144, " 17, *for* "reply usually" *read* "usual reply."

" 154, " 2, *for* "failure" *read* "neglect."

" 165, " 5 second par., *insert* "and" *before* "Consulting Preventive."

" 173, " 12 from bottom, *for* "high" *read* "great."

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GLOSSARY AND EXPLANATIONS

D.G.M.S. . .	The Director-General of Medical Services.
D.M.S. . .	Director of Medical Services.
D.D.M.S. . .	Deputy Director of Medical Services.
A.D.M.S. . .	Assistant Director of Medical Services.
D.A.D.M.S. .	Deputy Assistant Director of Medical Services.
M.O. . .	Medical Officer.
S.M.O. . .	Senior Medical Officer.
C.C.S. . .	Casualty Clearing Station.
O.C. . .	Officer Commanding.
E.E.F. . .	Egyptian Expeditionary Force.
D.A.G. . .	Deputy Adjutant-General.
A.A.G. . .	Assistant Adjutant-General.
D.A.A.G. . .	Deputy Assistant Adjutant-General.
3rd Echelon .	Records Department.
G.R.O. . .	General Routine Orders.
R.A.M.C. . .	Royal Army Medical Corps.
A.S.C. . .	Army Service Corps.
R.E. . .	Royal Engineers.
A.O.D. . .	Army Ordnance Department.
A.M.S. . .	Army Medical Service.
A.V.C. . .	Army Veterinary Corps.
A.P.D. . .	Army Pay Department.
A.I.F. . .	Australian Imperial Force.
N.Z.E.F. . .	New Zealand Expeditionary Force.
L. of C. . .	Lines of Communication.
G.H.Q. . .	General Head-quarters.
The A Branch .	Adjutant-General's-Department.
Categories:	
"A" . .	Fit for General Service.
"B.i. Front Line"	Various Grades short of General Service.
"B.i. L. of C."	
"B.ii. L. of C."	
"B.iii. L. of C."	
"D." . .	Temporarily Unfit.
D.A.H. . .	Disordered Action of the Heart.
V.D.H. . .	Valvular Disease of the Heart.

The following Standards were laid down as a guide to placing men in the various Categories:

Category "*A.*"—Able to march, able to shoot, hear well, and stand active-service conditions.

Category "*B.*"—Free from serious organic disease and in addition, if classified "B.i. Front Line" and "B.i. L. of C." able to march at least five miles, see to shoot with glasses, and hear well.

Category "*B.ii. L. of C.*"—Able to walk to and from work a distance not exceeding five miles, see and hear sufficiently for ordinary purposes.

Category "*B.iii. L. of C.*"—Only suitable for sedentary work or on such duties as storemen, batmen, cooks, orderlies, sanitary duties, etc. Also, if skilled tradesmen, fit to work at their trades.

A VISION OF THE POSSIBLE

SECTION I

A RÉSUMÉ OF PERSONAL EXPERIENCES AS A CONSULTING OCULIST[1] AND AURIST TO THE FORCES IN EGYPT

CHAPTER I

THE MANAGEMENT OF DISEASES OF THE EAR, NOSE, AND THROAT

In 1915 I was a member of the Australian Army Medical Corps, and was appointed Consulting Oculist (and informally Consulting Aurist) to the Force in Egypt. The conditions in Egypt in 1915 were almost indescribable. The pressure was intense and all medical officers were occupied in hastily improvised efforts to meet the oncoming rush from the Dardanelles. When, however, Egypt settled down in 1916 to what at first appeared to be a small undertaking, the aural problem was systematically attacked. On my return to Egypt in March 1916, after being invalided to England, the D.M.S. informed me that he had another Consulting Oculist, but that he required a Consulting Aurist, that the hospitals contained a large number of men suffering from ear diseases, and that such men were being invalided on an extensive scale; he directed me to visit

[1] For Ophthalmic work see Chapter IX., page 99 *et seq.*

all parts of the Field, to ascertain the precise position, and make recommendations to him.

I found two or three aurists doing excellent work either with their own or with improvised instruments, as there were very few appliances suitable for aural work in the country.

A large number of medical officers apparently did not realize that there was such a person as an aural specialist; consequently if a man appeared before one of the miscellaneous boards with a running ear, he stood an excellent chance of being invalided to England, and the number was added to by scores of such cases invalided to England from India, but detained in Egypt. The first requirement was to obtain aural specialists, and place them in certain strategical positions, to provide them with suitable instruments, and then to determine a policy. The D.M.S. effected these changes after consultation with me, and gradually aurists were appointed to each of the large hospitals, and the work commenced. As the line extended into the desert, aurists were placed at the rail-heads and on the line to act as screens, *i.e.* to examine all aural cases which passed through and determine whether they were cases which should be retained at the front or which should be sent down the line.

As the figures quoted later show, had the usual practice of performing radical mastoid operations on cases of chronic otorrhœa been followed, one or two base hospitals would have been required for the sole purpose of accommodating such cases. I advised the D.M.S. that in my judgment the risk to life from chronic otorrhœa was practically negligible if the purification method of treatment was carried out in a regular and systematized way, and that if he would permit me I

would see that the whole of the medical service became acquainted with the principles of the problem and that treatment was carried out thoroughly whilst the men were kept under observation; furthermore, that a competent aurist would be able to set aside doubtful cases which could receive special consideration. Whilst there was a remote risk of an accident taking place by the adoption of such a practice, the service would gain hundreds, and as it subsequently turned out, several thousands of soldiers. *Per contra* the real risk of hundreds of operations of luxury would be avoided. He authorized me to take this course, details of which are set out in the statement which follows. It is interesting to note in passing that the anticipated accidents never materialized on any extensive scale. As far as could be ascertained, the deaths from aural septicæmia in four years were about a dozen, and in most cases the men had never reported sick, and consequently there had been no treatment.

The following extract from the *Journal of Laryngology*, 1918, gives a general idea of the proceedings in the early period of the war:

SUMMARY OF REPORT ON DISEASES OF THE EAR, NOSE, AND THROAT IN EGYPT IN 1915

Part I

On arrival in Egypt in June 1915, there was no aurist available, and by direction an aural clinic was established at No. 1 Australian General Hospital, Heliopolis, in conjunction with the Ophthalmic Clinic, and was managed by the same staff, namely, two or three assistant surgeons, one medical student, and two nurses in the out-patient department, with the use of a ward of 100 beds. The assistant surgeons were mainly: Captain Morlet, Captain Stevens, Captain MacLellan, Captain Burke, and Captain Rosenfield, A.A.M.C., and Mr. Cook and Mr. Wharton, medical students. The work was even heavier

than the ophthalmic work, largely owing to the outbreak of measles which occurred amongst the Australian troops soon after landing in Egypt. Work continued so far as I was concerned until I was invalided to England in November 1915. The first part of this report deals entirely with the period referred to in 1915.

1. *General.*—The problem of dealing with diseases of the ear, nose, and throat differs essentially from that presented to the oculist. As pointed out in another place, the work of the oculist in the army is a diminishing quantity up to a point, because once the refractions of those complaining have been worked out and glasses fitted, the refraction work is at an end, except in so far as new drafts are concerned. On the other hand, there are a very large number of soldiers who have been enlisted suffering from otorrhœa with foul discharge, a condition which in many cases had existed for years previously. They make their appearance at the base hospitals and require attention, and are disposed of in the manner indicated later. There are in addition a large number of ear, nose, and throat cases who suffer from enlarged tonsils, adenoids, nasal obstructions, or diseases of the sinuses, contracted prior to enlistment. The precise number of men who suffered from these varying conditions cannot be exactly estimated, but in Egypt they were several thousands. But when all these men have been finally disposed of, there remains a steady inflow of new cases who suffer from ear, nose, and throat diseases contracted whilst on service. It follows, therefore, that the clinical problem of ear, nose, and throat diseases is not a diminishing one to the same extent as the problem presented to the oculist, and the provision necessary to be made consequently differs considerably. The military work in both cases is important and similar in character.

2. *Statistical.*—The following figures furnish a rough classification of the diseases treated, but they do not indicate the total. It should be remembered that in addition to the cases treated at Heliopolis, many cases were seen at No. 2 Australian General Hospital, at Helouan, and elsewhere:

Aural, Nasal, and Throat Cases

Acute Catarrh (Middle Ear)	95
Chronic Catarrh (Middle Ear)	435
Oto-Sclerosis	138

To face page 1

EGYPT AND THE WESTERN DESERT: THE OASES

Cerumen	190
Otitis Externa	143
Concussion Deafness	139
Nasal Catarrh	114
Septal Deflection	96
Adenoids	74
Polypi	4
Enlarged Tonsils	12
Antra and Sinuses	14
Pharyngeal Catarrh	11
Aphonia	8
Laryngeal Growth	1
	1,474

Operations Performed

Aural:		
Mastoid Operations	17	
Removal F. B.	3	
		20
Nasal:		
Adenoids	73	
Spurs	34	
Polypi	14	
		131
Throat:		
Tonsils		41
		162

The experience was that, even at the outset, far more clinical work was done in the aural than in the ophthalmic division.

3. *Severity of Acute Otitis.*—The chief characteristic of the cases seen at Heliopolis was the severity of the attacks of acute inflammation of the middle ear. It should be remembered that severe cases of measles and broncho-pneumonia were frequent. There were generally about 100 measles cases under treatment, and a steady stream of cases of acute inflammation of the middle ear flowed into Heliopolis, sometimes in association with measles, sometimes without apparent association. The men,

however, suffering from acute inflammation of the ear were often seriously ill, the temperatures were often 103° Fahrenheit, and at the end of a sharp attack the convalescent patient looked thoroughly exhausted. The severity was so marked, and the condition so unusual, that the pathologist of the hospital, Captain Watson, made careful search, but found nothing except staphylococcus.

4. *Adenoids.*—Another feature was the prevalence of adenoids. It is difficult to believe that these men enlisted with adenoids, since I have never seen so many adenoids in adults during a long period of private practice, and I am inclined to attribute the prevalence to the dust of the desert, laden as it is with organic matter, and to the severe colds from which these men suffered.

5. *Otitis Externa.*—It will be noticed that under the heading "Otitis Externa" there are a considerable number of cases. The prevalence of this condition usually associated with otorrhœa, but sometimes independent of it, continues to the present day. This extensive distribution of furunculosis is in my experience peculiar to Egypt.

6. *Concussion Deafness.*—A large number of men complained of deafness due to shell-shock. A number of the cases were not genuine, but a considerable number presented the usual symptoms of unilateral deafness due to gunfire. In some cases the membrane was ruptured, but they were not very numerous. Bilateral cases of concussion deafness were in almost every instance cases of hysterical deafness, and they underwent a remarkable recovery when placed on rigid treatment, and particularly when subjected to faradization through the mastoids.

7. *Malingering.*—The difficulty of discriminating between the real and the false is much greater in the case of deafness than of blindness, because an ear which appears fairly normal may be associated with oto-sclerosis and deafness. A number of mis-statements were made by men with regard to their hearing and a number of devices were resorted to in order to detect the fraud. Of these, the most successful were the bandaging of the eyes and the testing of the hearing at different distances by unknown sources of sound. The examinee is unaware of the distances at which a noise-producing apparatus is placed, and gives discrepant answers. He is further unaware

of the nature of the Rinne test by the tuning fork, or of the fact that in middle-ear deafness a tuning fork placed in the vertex is not infrequently heard best in the damaged ear, or in an ear artificially plugged. By these and a set of many other devices, it was possible to show that in a number of cases the degree of hearing possessed did not correspond with the physical appearances of disease, and that it varied from minute to minute. Before leaving this subject, however, I should like to say again, both with regard to the ophthalmic and the aural work done, that I should be sorry indeed to suggest that this attitude applied to more than a very small percentage of the men who came to the hospital, and who really represent what may be termed the " pathological residuum of the army."

8. *Operations of Election.*—As regards nose and throat diseases a large number of patients presented themselves suffering from deviation of the septum and nasal spurs. It was obvious that they had suffered from these conditions all their lives, and that they had never troubled about them before. They were accordingly sent back to duty in the majority of cases with the advice that they could get them attended to when the war was over.

9. *Fitness for Service.*—In the case, however, of the men who suffered from some degree of deafness, or from chronic otorrhœa, the important question arose of their fitness for service. If all the patients who suffered from chronic otorrhœa were to be discharged from duty, a number of fit men would be dismissed from the army after the heavy expense had been incurred in sending them to and from Egypt. The risk of cerebral or general infection from otorrhœa is very small. This fact is abundantly proved by the large number of soldiers who suffer from this condition, and who have disregarded it for many years, or for the whole of their lives, and from the rarity with which cerebral or general infection is seen. During the whole of my work in Egypt, extending now for eighteen months, I have seen only two cases of generalized septic infection from otorrhœa. It seemed better to instruct the patient carefully respecting the cleaning of the ear, to curette out any polypi or granulation tissue, and to send him back to work. So far as deafness is concerned, a considerable degree of deafness, definitely proved, seems to me to warrant placing the soldier in Class " B " per-

manently. A moderate degree of deafness, nevertheless, permits him to discharge all duties except forward sentry work. It is not safe to put a man who is deaf, or thinks he is deaf, in such a position. The broad view was taken, that as this is a national war all men possible should be employed. These deaf or partially deaf men are all capable of earning a living in civil life in some capacity or other, and indeed do so. There must be some position in the army for which they are fitted.

Part II. 1916 and 1917

10. *Improved Organization.*—On return to Egypt in March 1916, I was appointed Consulting Aurist to the E.E.F., and have occupied that position ever since. In 1916 Egypt was well organized. The period of improvisation was over, appliances were available, and the problem was essentially different. A large number of clinics were established, aurists being placed at the principal base hospitals and, as time progressed, also in the stationary hospitals, in casualty clearing stations, and even in the field ambulances.

11. *Functions of Aurists.*—The functions, however, of the aurists in the base hospitals, and in the other units on the lines of communication, were essentially different. The usual practice has been to transfer a man to the base who reports sick with ear, nose, or throat disease for the first time, unless the case is trivial. The case is thoroughly examined and treated at the base hospital, and is then returned to the front, a full clinical report being sent to the A.D.M.S. of the division. The case cannot be sent down a second time unless symptoms have redeveloped, and without examination by an aurist in a field ambulance or on the lines of communication. Consequently it is the business of the aurist placed on the lines of communication to treat and return to the front all comparatively unimportant cases, and to transmit to the base, as speedily as possible, anything of importance. As these arrangements were completed, the bulk of the work was transferred from the base to the forepart of the lines of communication.

12. *Distribution of Cases.*—The statistics show that the aural cases constituted two-thirds to three-quarters of the total work of the aurist. Nasal, pharyngeal, and laryngeal diseases, apart from diphtheria and tonsillitis, constituted one-quarter to one-

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THE CANAL ZONE, SINAI, AND PALESTINE

third of the total, and of the aural diseases, the infections group, namely furunculosis and chronic otitis media, were at least two-thirds of the total.

13. *Treatment Adopted.*—For the purpose, then, of producing efficient soldiers, the problem became one of the management of otitis media and furunculosis. The method of treatment adopted in these cases is indicated in the circular which follows. I think it is probably correct to say that never before in any civil clinique has the treatment been carried out in the same thorough and systematic manner. It would certainly be impossible in civil life to be sure that people dry out the last minim of pus in the ear in the same way that the instructed soldier does. The result has been remarkable, and every specialist in Egypt has been impressed with the fact that otitis media, with foul discharge, of long standing, sometimes of years, has been brought under control and often cured in a few weeks by this simple purification method. They have further become convinced that the radical mastoid operation, so often performed in civil practice, begins to appear in the light of a luxury, as it certainly is not usually a necessity. There are, so far as I am aware, very few cases in which a general infection has taken place from an ear which was under treatment. The few infections, about a dozen, which did take place during nearly three years were mostly in cases which had not reported sick, and had apparently never received treatment.

14. *Statistical.*—The statistical table which follows applies only to a portion of the period. It is not published with a view of giving any idea of the absolute number of cases treated, but with a view to indicating their relative distribution:

Statistics relating to Distribution of Diseases of the Ear, Nose, and Throat

Aural Diseases:

External Ear:

Cerumen	332
Otitis Externa and Furunculosis	352
Eczema	47
Injuries and Foreign Body .	7

Aural Diseases (continued):

Middle Ear:

Acute Otitis Media (dry)	23	
Chronic Otitis Media (dry)	371	
Acute Otitis Media (suppurative)	65	
Chronic Otitis Media (suppurative)	1,173	
Mastoiditis	33	
Gunshot wound	5	
Injury	8	
Miscellaneous	25	
Internal Ear	30	
		2,471

Nasal Diseases:

Acute Rhinitis	6	
Chronic Hypertropic Rhinitis	127	
Chronic Atropic Rhinitis	53	
Injury	7	
Septal Deviation	88	
Polypus	36	
Epistaxis	13	
Sinusitis (General)	19	
Sinusitis (Frontal)	10	
Sinusitis (Maxillary)	21	
Gunshot Wound	19	
Miscellaneous	30	
		429

Naso-Pharynx Disease:

Adenoids	28

Pharyngeal Diseases:

Tonsillitis	248	
Enlarged Tonsils	241	
Pharyngitis	56	
Diphtheria	5	
Miscellaneous	15	
		565

Larynx, Disease of:		
Acute Laryngitis	15	
Chronic and Subacute Laryngitis	61	
Neurosis and Aphonia	26	
Paralysis	2	
Tubercle	2	
Gunshot Wound	5	
Miscellaneous	36	
	——	147
Miscellaneous and Malingerers		22
		3,662

Operations Performed

Aural:		
Removal of Polypi and Granulations	60	
Mastoid	43	
Furuncle	13	
Miscellaneous	14	
	—	130
Nasal:		
Submucous Resection	23	
Turbinated Excision	84	
Turbinated Cautery	24	
Polypi	61	
Maxillary Antrum	28	
Frontal Sinus	1	
Miscellaneous	24	
	—	245
Naso-Pharyngeal:		
Adenoids		39
Pharyngeal:		
Operations on Tonsils	170	
Miscellaneous	1	
	——	171
		585

15. *Shell-Shock.*—A good deal of discussion has arisen from time to time as to whether there is such a thing as deafness as the result of shell-shock or nervous disturbance. The malingerer is not uncommon, but he can usually be detected. Men suffering from hysteria are not uncommon, certainly far more common than in civil practice. Unilateral deafness due to gunfire or shell explosion is not uncommon, and rupture of the drum due to the same cause is not infrequent; but when we have eliminated the malingerer, the sufferer from bilateral hysterical deafness, and unilateral deafness due to gunfire, is there such a thing as bilateral deafness due to shell-shock? Personally I have not seen such a case, but some of the aurists in Egypt state they have seen odd cases where the deafness appeared to be labyrinthine in origin. I feel inclined to sum up the position with regard to deafness in the same manner as I summed it up with regard to blindness: that deafness due to genuine shell-shock was a rare condition; that hysterical deafness, due to nervous collapse under the circumstances of war, was fairly common, and usually remedied with ease. In the discrimination between the cases of organic disease and the cases of hysterical deafness, the caloric test was freely used. Where the result was negative, the fine question was opened up as to whether the loss of the vestibular reaction implied the destruction of the cochlea. An attempt was made to settle the question by the use of the Wassermann reaction, as at least one case of loss of cochlear function, supposed to be due to shell-shock, turned out to be due to syphilis.

Conclusion.—The principal business of the aurist in the war zone is to see that cases of chronic otitis media are efficiently cared for, and are kept on duty at the front. Apart from this paramount duty, he will have a good deal of work to do in recommending cases of deafness due to dry catarrh for classification, and a certain amount of work to do on the lines usually followed by a specialist in civil practice, subject to the proviso that any condition that may have existed prior to the war can wait till the war is over for rectification, unless it distinctly interferes with the man's efficiency as a soldier.

CHAPTER II

THE MANAGEMENT OF EAR, NOSE, AND THROAT DISEASES (*continued*)

THE following article appeared also in the *R.A.M.C. Journal*, 1917 :

A note appears in the November 1916 number of the *Journal of The Royal Army Medical Corps*, from the pen of Major James Kerr Love. The title of the note is "Hearing in the Army," and the article raises a number of problems to which I desire to make very brief reference.

Those experienced in the matter will entirely agree with the statement made by him that :

(1) Most of the cases of deafness amongst those invalided home are due to middle-ear suppuration, and

(2) That middle-ear suppuration has in most cases existed before the war began—indeed for years before the enlistment of the soldier.

The question, however, immediately arises : Is it necessary to invalid a soldier because he has a suppurating ear ? Statistics, I understand, cannot be published during the continuance of the war, but those who are thoughtful might well ask what would be the practical effect of agreement with such a policy ? The facts are that the majority of cases of suppurating ear possess good or fair hearing ; of the minority, a number can be much improved by treatment, and the residuum of cases, in which the hearing is greatly deficient, or the discharge unmanageable, is comparatively small in number. The majority of these cases have existed for considerable periods of time, and have not been subjected to regular treatment, and when placed under regular supervision and treatment by the purifi-

cation method do very well. The treatment can be applied without much difficulty at the front, after preliminary treatment at the base.

Furthermore, is it not obvious that this is a national war, waged by a national army, and that as these men, in civil life, are able to earn a living in some capacity, so when the nation has turned its attention to military matters there must be some occupation in which even those with defective hearing can find opportunity for useful service? Is it not the case that the problem usually faced in recruiting has now been completely altered? An army of limited size can be, and should be, composed of picked men with as few defects as possible, but the existence of the same standard in a national war may make a serious difference in the number of men available.

So far as the test of hearing is applied on admission with the object of eliciting remedial defects, there can be no criticism, but I should be sorry to depend on the answers to test questions for a determination of the acuity of hearing of all recruits. Nothing in my judgment is so difficult as the determination of the amount of hearing possessed by anyone who is unwilling to hear, and candidates who may desire to evade service would be very difficult to deal with by the estimation of their capacity to hear whispering at specific distances. It is true that this criticism will not apply to the great majority of candidates, but amongst the minority the person who will offer the most difficulty is he who possesses some aural disease and tries to make the most of it. For this type of candidate there is no more suitable method of testing than the use of the tuning fork with the various devices well known to aurists.

Nothing has been more striking in my experience of suppuration of the middle ear than the infrequency of general septicæmia. Ears wholly neglected by men for many years rarely land their possessor in serious trouble. Whether their comparative immunity is due to the free exit for discharge, to the development of antibodies, or to the creation of an anatomical bar to infection, it is difficult to state; but of the fact there is no doubt whatever, and those who have handled considerable numbers of cases have been surprised at the relative infrequency with which the radical mastoid operation is necessitated. The purification method of treatment carried out under discipline reduces the problem to very small proportions. The experience

of the war will cause many of us to modify our notions respecting the management of chronic otitis media.

In 1918, it was possible to keep statistics with greater accuracy, and the following table shows the nature of the work done:

SUMMARY OF DISEASES OF THE EAR, NOSE, AND THROAT

Period: January 1 to September 31, 1918

Aural Disease:		
External Ear:		
Cerumen	1,035	
Otitis Externa and Furunculosis	1,411	
Eczema	290	
Injuries and Foreign Bodies	52	
Middle Ear:		
Acute Otitis Media (dry)	193	
Chronic Otitis Media (dry)	991	
Acute Otitis Media (suppurative)	605	
Chronic Otitis Media (suppurative)	2,969	
Mastoiditis	95	
Gunshot Wound	31	
Injury	30	
Miscellaneous	299	
Internal Ear	174	
		8,175
Nasal Disease:		
Acute Rhinitis	94	
Chronic Hypertropic Rhinitis	486	
Chronic Atropic Rhinitis	93	
Injury	37	
Septal Deviation	421	
Polypus	141	
Epistaxis	92	
Syphilis	9	
Sinusitis (General)	35	
Sinusitis (Frontal)	46	

Nasal Disease (continued):		
Sinusitis (Maxillary)	95	
Gunshot Wound	41	
Miscellaneous	174	
		1,764
Naso-Pharynx Disease:		
Adenoids		139
Pharyngeal Disease:		
Tonsillitis	1,150	
Enlarged Tonsils	389	
Pharyngitis	235	
Diphtheria	169	
Miscellaneous	91	
		2,044
Larynx, Disease of:		
Acute Laryngitis	151	
Chronic and Subacute Laryngitis	84	
Neurosis and Aphonia	70	
Paralysis	11	
Neoplasm	6	
Tubercle	29	
Syphilis	17	
Gunshot Wound	10	
Miscellaneous	21	
		399
Miscellaneous and Malingerers		127
Total		12,648

OPERATIONS

January 1 *to September* 30, 1918

Aural:		
Removal of Polypi and Granulations	141	
Mastoid	48	
Furuncle	134	
Miscellaneous	51	
		374

Nasal:		
Submucous Resection	83	
Turbinated Excision	112	
Turbinated Cautery	108	
Polypi	115	
Maxillary Antrum	65	
Frontal Sinus	7	
Miscellaneous	36	
	——	526
Naso-Pharyngeal:		
Adenoids		111
Pharyngeal:		
Operations on Tonsils	282	
Miscellaneous	11	
	——	293
Laryngeal:		
Tracheotomy		5
Miscellaneous:		
General		11
		1,320

STATISTICS RELATING TO INFECTIOUS AURAL DISEASES

January 1 *to September* 30, 1918

Otitis Externa and Furunculosis	1,411
Eczema	290
Acute Otitis Media (suppurative)	605
Chronic Otitis Media (suppurative)	2,969
Mastoiditis	95
	5,370

In order to make the system workable, the following

instructions were issued to *every Medical Officer in Egypt*:

INSTRUCTIONS IN REGARD TO CHRONIC OTITIS MEDIA

1. There are in Egypt a very large number of men who are suffering and have suffered from chronic suppuration of the middle ear and furunculosis. The number amounts to several thousands, and in a very large number of cases this is their only disability. If the disease were regarded as a military disability, the strength of the force would be affected to a great extent. Largely owing to the experience gained, it has become obvious that with reasonable care the risk of general infection is slight, and as a matter of fact many of these men have suffered from chronic otitis media through the greater part of their lives. Chronic otitis media, therefore, only becomes a military disability when it seriously involves hearing, or in the rare cases when it threatens general infection.

2. The practice usually adopted is to send a man who reports for the first time with this condition into the nearest hospital available, so that the ear may be thoroughly examined, cleaned, and freed from granulation and polypi. The man is then taught how to clean the ear himself, in accordance with the circular which follows. He is then returned to his unit and a full report of his case is sent to the A.D.M.S. of his division by the officer commanding the hospital in which he has been treated.

3. There are, however, a number of minor cases which do not need hospital treatment. These men are seen by aurists in the field ambulances and by aurists in the C.C.S.s or stationary hospitals on the lines of communication. These aurists can deal with those who require brief attention, and return them to the lines speedily, and, consequently, the number sent to the base hospitals can be reduced to comparatively small proportions. A case returned with report to the A.D.M.S. Division should not be sent down the line a second time, unless symptoms have appeared which indicate general infection, genuine deafness, or a marked local aggravation.

4. In general, cases may well be returned to the front in which discharge has ceased, or is mucoid and quite moderate in quantity. Cases in which there is profuse purulent discharge

which does not give way readily to the purification treatment should be submitted for classification, but such cases are few in number.

5. It will be understood from the foregoing that every effort should be made to prevent these cases being sent down the line unless it is absolutely necessary, and equally, that the few cases which show serious symptoms should be passed to the base as quickly as possible.

6. The following indicates the procedure it is most convenient to adopt in the purification method of treatment:

(1) The patient should pass the hand of the side opposite to the ear affected over the top of the head and seize the upper part of the ear with the finger and thumb. The ear should then be drawn upward. This straightens out the ear canal. A small piece of wool should be firmly wrapped round a wooden match and introduced into the ear passage with the disengaged hand to a depth of about three-quarters of an inch to one inch. No force should be used, but, with care, the matter can be mopped out and the ear rendered quite dry.

It is desirable to cut off the end of the match used for ignition.

(2) The head should be turned on the sound side, and the diseased ear passage filled with the drops (which should be warmed in winter). The drops should be allowed to remain in the ear five minutes.

(3) The ear passage should again be thoroughly dried out.

(4) A small piece of wool should then be placed in the ear to exclude dirt.

The most convenient drops for general use are:

Spirit Vini Rectif
Lotio Acidi Carbolici (1 in 15) } Equal parts.

The patient should be inspected by the medical officer once a week.

7. Aural specula are available for M.O.s to units, and car, nose, and throat instruments are supplied to field ambulances and C.C.S.s on a definite scale, so that every facility is given for the development of the policy indicated in the circular. If any difficulties arise, representation is to be made, through the usual channels, to the D.M.S.

The following circular was issued to all Casualty Clearing Stations and Stationary Hospitals:

INSTRUCTIONS FOR AURISTS IN CASUALTY CLEARING STATIONS AND STATIONARY HOSPITALS

So far as diseases of the ear, nose, and throat are concerned, the duties are mainly to advise which patients should be retained at the front, and which should be returned to the base.

Soldiers complaining of ear, nose, and throat diseases who have never reported sick with those diseases before are to be sent to the base unless the complaint is trivial. At the base they are fully examined and treated, and when returned to duty a full clinical report is sent to the A.D.M.S. of the division, who forwards it to the medical officer of the unit. There, consequently, should be no reason for sending these men back a second time unless some serious complication or development has occurred. There is an aurist in one field ambulance in each division, and a man returned in this way may have seen this officer. If he has, and this officer has recommended his return to the base, such recommendations should not be lightly interfered with. For those who have not seen an aurist in the field ambulance, their disposal is a matter for your own judgment. If the case is simple, and in your opinion can be readily dealt with in a few days, it can be treated either in the C.C.S., or sent back to the lines with a note to the medical officer in charge.

The following are some of the conditions which necessitate return to the base:

(1) Any case which shows pronounced and genuine deafness not remediable by simple means.
(2) Any discharging ear accompanied by genuine and severe pain.
(3) Any discharging ear with œdema over the mastoid.
(4) Any discharging ear with high temperature or other signs of general infection.

Any case returned must be accompanied by an explicit report.

Your function is mainly to secure the immediate transmission of serious cases to the base, and to keep the whole of the lighter and the trivial cases at work at the front.

Any instruments or appliances you may require are to be obtained through the ordinary channels.

Even with these precautions the system could not work satisfactorily without the hearty support of the A.Ds.M.S. of the forward area, and two conferences were held with these officers under the presidency of the D.D.M.S., so that the problem might be fully considered. It was ultimately agreed that every ear case which was not trivial should be sent to a base hospital in the first instance, and that when he was discharged to duty the medical officer commanding the hospital should forward the following certificate to the A.D.M.S. of the Division. By this means the A.D.M.S. of the Division became aware of the extent and nature of ear diseases amongst his men, and was enabled to keep in touch with the movement.

The following is a sample of the note usually forwarded to the A.D.M.S. Division :

No.....
Name.....
Number..... *Unit*.....
Rank .....
A letter was sent respecting this man to.....
on.....*day of* .....191...

No.....

EAR, NOSE, AND THROAT CASES

To the Medical Officer of the Unit

The Soldier respecting whom particulars are hereby given was discharged from

..... *Hospital*
on the.....*day of*.....191..

PARTICULARS

Name .....
Number..... *Rank*.....
Unit .....
He was discharged to duty.
He was discharged to Convalescent Home.
He was suffering from.....
The following treatment is recommended.....:
.....
.....
.....
.....
.....
This man was examined by the Consulting Aurist, who concurs in this Report.

Signed.....

The result of these efforts was that ear disease became negligible in importance, though it remained considerable in extent, because every medical officer in the army understood how to handle it. I wish, however, to lay stress on the fact that this result, which added thousands of men to the effective strength of the E.E.F., was not only due to the hard and painstaking work of the thirty-odd aurists who were distributed about the Field, but to the educational means adopted. The whole service was taken into confidence, the problem was explained, and the help of the medical officer was invited. This policy wiped out what had become an almost intolerable nuisance, namely, the constant procession to the base of men with ear diseases. With the knowledge gained the medical officers were confident in their judgment and knew that the risks run were negligible.

Let me ask what would have been the effect, had a similar method been applied to other medical prob-

lems? Why should not an A.D.M.S. or Consultant for Venereal Diseases have been appointed, whose province it was to know everything relating to venereal diseases which could be known; and if after receiving his advice the D.M.S. had taken the whole service into his confidence as to the best method of dealing with the problem? Wherever this method has been applied it has been successful. There was in the E.E.F. an able heart specialist, and ultimately his services were employed by establishing a heart clinic at the hospital in association with an assistant in a command depot, so that men's hearts were judged, not so much from the result of physical examination, but from the capacity of the heart to stand graduated work. The result of the work of these two specialists, namely, the specialist in the hospital and the subordinate in the command depot, was practically to eliminate D.A.H. as a disability. Soldier's heart ceased to be of much importance, and by a similar educational process everyone gradually understood the problem. In my judgment, one of the failures of the R.A.M.C. has been the inability to recognize the importance of stimulating enthusiasms by explaining the issue. Wherever the converse course has been followed, with the necessary restrictions, it has been signally successful.

Surgical Instruments, Etc.

The instruments, appliances, and drugs supplied by the War Office were, on the whole, very good. After much discussion, a proper system was established. The Consulting Oculist, Consulting Aurist, and the Consulting Dentist periodically visited the base stores, and the officer commanding the store invariably consulted

them before ordering supplies from London. They standardized instruments, and did their best to meet the requirements of the various specialists without being extravagant, and kept a monthly return of the supplies. For some time, however, the D.M.S. insisted on some of the requisitions going to him, and he only referred to the Consultant when he thought fit. The result was unsatisfactory and the more sensible plan alluded to was adopted. The final result was that indents for instruments required countersigning by the Consultant of the several departments, and by this method supplies of instruments were kept down to a reasonable basis. For, as time passed by, civilian specialists full of enthusiasm arrived in Egypt, and commenced to order (say) Howard's, or Smith's, or Jones's specula; and had the system been allowed to continue, Egypt would soon have contained a museum of all sorts of odd instruments. These practitioners were, however, sensible, and when the position was explained to them were quite willing to adopt instruments of a uniform pattern.

Like some other branches of the service, towards the end of the war this division became very efficient.

SECTION II

THE WORK OF STANDING MEDICAL BOARDS

CHAPTER III

STANDING MEDICAL BOARDS

At the end of 1916, Standing Medical Boards in Egypt were in an extraordinary position. Each hospital or camp held its own Board with varying personnel, with the sole exception of Cairo, where the A.D.M.S. Delta, himself a physician, presided over a certain number of the Boards for such time as he was able to give. The result was that a large number of men were invalided to the United Kingdom for trivial diseases. The classification standards varied not only with the different Boards, but also with different sittings of the same Boards, because of the varied personnel of the Board, and the finding of the Board was difficult to ascertain if the man moved to another hospital or camp. The medical history sheet had been abolished during the war and nothing had been substituted for it.

At about the end of 1916, whilst the multiple Board system was being generally adopted, the Germans threatened to submarine all hospital ships, and, in consequence, invaliding from Egypt was reduced to a minimum. It is a remarkable fact that, when the position eased with the appointment of the Spanish Commissioners, a great majority of the men suffering

from ailments for which they would formerly have been invalided had practically recovered, and were doing duty.

At the beginning of 1917, as the Army grew, the A.D.M.S. Delta was unable to continue the work, and the D.M.S. asked whether I was willing to undertake it. He explained that it was an experiment, an experiment that might well be tried, and he hoped I might be successful. I agreed to do so, and became President of all the Boards in the E.E.F. exclusive of Alexandria. The Board in Alexandria was soon afterward similarly placed under the presidency of Lt.-Col. Eason, C.M.G. The D.M.S. gave me two pieces of advice, characteristic of all that is best in the old army, namely, to be impervious to influence of any description that might be brought to bear, and to accept the statement of any officer who appeared before the Board as true, unless there was overwhelming evidence to the contrary. The work began. There were no standards known to me, I did not know at that time precisely what the soldier did, and I had nothing to guide me except a G.R.O. which is referred to later. There was no proper form on which returns should be made, and the principles which were to guide the work of the Board were not well known. It is unnecessary to follow the development step by step, but the work became enormous in its extent, and the duties of the Board became those of recommending soldiers to be invalided to England, recommending the classification which should be adopted if they remained in Egypt, advising the Commissioner of Pensions respecting pensioners, making recommendations respecting men who applied for commissions, and finally making a most extensive set of recommendations relating to the repatriation of prisoners

of war. In about four months' time I had begun to grasp the principles concerned, and, after discussion, the D.M.S./E.E.F. issued the following memorandum:

MEMORANDUM RELATING TO THE INVALIDING AND CLASSIFICATION PROBLEM

Invaliding.—Sick or wounded who, in the opinion of the medical officer in attendance and the commanding officer of the hospital, are not likely to be fit for military service in any class within five months, should be brought before one of the Invaliding Boards appointed for the purpose. The Invaliding Board will, after careful examination, answer the question whether the patient is likely to be fit for any kind of military service for five months; and if the answer be in the negative, will recommend he be classified "C" (*i.e.* invalided to England).

The members of Boards are reminded that length of service in Egypt or other compassionate considerations are not to be considered by them. Their function is limited to giving a direct answer to the question above stated.

Temporary "B" Class.—Patients discharged from hospital (or convalescent depots) who, in the opinion of the medical officer and the officer commanding the hospital, are likely to be fit for Class "A" within five months, and are fit for some military service at the time of discharge, may be marked "Temporary Base."

When so discharged to Base Depots, the officer commanding shall send a nominal roll and concise clinical information. These particulars will be transmitted to the O.C. Base Depot, through the A.D.M.S. of the District in which the Base Depot is placed. It is to be understood that the man is only to be marked "T.B." for a specified period, and in no circumstances is the period to exceed three months primarily.

"B" Class.—Men discharged from hospital who are not likely to be fit for Class "A" at the expiration of five months, and who are fit for some kind of military service at the time of discharge, should be classified "B. i," "B. ii," or "B. iii," in accordance with existing orders and practice.

It is better that this classification should be effected whenever practicable at the time of discharge from the hospital, and at the hospital.

Men not Previously Classified.—There are a large number of men who have not been previously classified, or concerning whose classification there are no records available. The A.D.M.S. or the D.D.M.S. of the District may establish Temporary Classification Boards with authority to class those men "A" whom those Boards think "fit." All men who are regarded by the Temporary Board as not certainly fit for Class "A" should be referred for classification to the Standing Boards of which Lieutenant-Colonel Eason and Lieutenant-Colonel Barrett are presidents.

Mode of Record.—In all cases of classification the "Medical Classification form" should be filled up and signed by the members of the Board in triplicate. One copy must be sent to the A.D.M.S. or D.D.M.S. of the District, one to the A.A.G. 3rd Echelon, and one to the Officer Commanding the Unit. In those districts where the A.D.M.S. or D.D.M.S. wish to ratify the proceedings, the latter two copies cannot be dispatched until formal approval has been given. The decision of the Board, whether "A," "B," or "T.B." together with the disability and principal clinical notes copied from the Medical Classification form should be entered in A.B. 64 (the man's paybook), except in those cases where it is thought desirable to transmit the information confidentially to the man's unit, when a separate memorandum should be forwarded to the A.A.G. 3rd Echelon for transmission.

Examination at the Base Depots.—All men marked "T.B." should be paraded on arrival at the Base Depot before the medical officer in whose charge they are placed, and he shall examine them once a week, recording his opinion. When he thinks they are fit for duty, or when the term for which they have been classed "T.B." expires, they shall be brought before the Standing Classification Board, who may extend the period or classify them definitely. The Standing Board may, however, call for presentation of any or all of these "T.B." cases at any time it desires.

The medical officer in charge of the case should be present at the sitting of the Board, or, if that be impossible, shall furnish a report in writing respecting the cases dealt with.

Men in Garrison Battalions and Other Men marked "B."—All men in Garrison Battalions, or other men classed "B," shall be examined once a month by the medical officer of the unit,

who shall record his opinion. If he is of opinion that any change of classification is requisite, he shall present the case at the next sitting of the Standing Medical Board. He should be present at the sitting of the Board, or, if that be impossible, shall furnish his information in writing.

It is understood, however, that the Standing Medical Board may call for the presentation of any or all of the cases in his charge if at any time it be thought necessary.

Procedure.—It should be clearly understood that cases cannot be presented to any Invaliding or Classification Board without a definite clinical report from a medical officer. It is this report which forms the basis of the proceedings of the Board, and the facts it embodies are the cause of its action.

This document was of course based on a General Routine Order (G.R.O.), but was issued as an instruction to all medical officers in Egypt. The proceedings of the Boards immediately became intelligible. The work was systematized and the foundation was laid for further developments. For the first time medical officers understood precisely what was expected of them. Working on this basis, problem after problem made its appearance, difficulty after difficulty arose, and these were submitted to the A.D.M.S. or D.M.S. as the case might be, and rulings obtained, sometimes by a direct order from the D.M.S., sometimes by G.R.O. In addition to this, a series of Army Council instructions made their appearance defining procedure and setting physical standards under certain conditions. Furthermore the knowledge of the consulting surgeons and physicians was utilized and gradually a set of clinical standards was laid down. All this work, however, took several months, and by the time it was approaching fruition the mass of orders, amendments of orders, Army Council Instructions, and G.R.O.s had become bewildering. With the permission of the D.M.S. I then set to work to codify the law as it stood up to date

after consultation with the presidents of the other Boards, and in February 1918 a complete statement of the position was issued to every medical officer in Egypt in the form of a printed document of thirty-one pages.

Orders, Amendments of Orders, and Army Council Instructions continued to appear, and a revised edition was prepared in somewhat altered form and made ready for issue just before the termination of the war. This revised edition now follows in full, and represents the culmination of two years' work.

CHAPTER IV

THE MEMORANDUM

Authority.—The following is a précis of the regulations laid down with reference to Classification Boards, and compiled from General and Routine Orders, quoted textually or amended in places in conformity with the instructions of subsequent General Routine Orders.

Those who are desirous of verifying their reference or of testing the accuracy of the précis are referred to the following General Routine Orders.

I. MEDICAL CATEGORY ON DISCHARGE FROM HOSPITAL

Officers and men discharged from Hospital will be classified as under:

Class "A." Officers and men fit for general service in any theatre of war.

Class "A" will be sub-divided for purely military purposes into two headings as under:

"A.i." Officers and men fit for general service in any theatre of war in all respects, both as regards training and physical and mental qualifications.

"A.ii." Officers and men requiring further training before classified "A.i."[1]

Note.—All Officers and men falling under either of the above headings will, on discharge from Hospitals, be classified by the

[1] G.R.O. 3480, dated 31/1/18.

medical authorities Class "A" and will be sub-classified "A.i" or "A.ii" by Officers Commanding Base Depots.

Class "B." Will be sub-divided under the following headings:

"B.i." Not fit for general service, but fit for service in Garrison Units, Area Employment Companies, or duties of an analogous nature in the E.E.F.

"B.ii." Not fit for general service, but fit for service in Garrison Units, Area Employment Companies, or on garrison or regimental outdoor employment in the E.E.F.

"B.iii." Not fit for general service, but fit for service in Garrison Units, Area Employment Companies, or sedentary work as clerks, storemen, cooks, batmen, orderlies, or on sanitary duties, etc., and, if skilled tradesmen, at their trades in the E.E.F.

Classification Boards will give an opinion as to how men Classified "B.i," "B.ii," or "B.iii" should be employed, *i.e.* fit for lorry driver, horse transport duties, cyclist orderly, general work, sanitary duties, and in the case of men possessing a trade, whether he is fit for employment at it, and in all cases whether (1) fit for front-line formation, (2) for work on L. of C.

This will in every instance be entered in A. B. 64. (A. (M) 71.)[1]

Class "D." Temporarily unfit for service in Categories "A" or "B," but likely to be fit within six months.

Class "D" will be subdivided as under:

"D.i." Officers and men in Command Depots.

"D.ii." Officers and men in Base Depots.[2]

Note.—Category "D" is purely a temporary one, and men in a higher category automatically become "D" if under medical or dental treatment. When such medical or dental treatment is finished they automatically rejoin their original category until transferred upwards by the Medical Officer of the Unit or Medical Board, or downwards by Medical Board.

I. (*a*) Indian Officers and Other Ranks (including Followers) discharged from Hospital will be classified as under:

Class "A." Fit.

"B." Fit for Service on L. of C. only.

"C." Invalids for India.

"D." Temporarily unfit for front line.

[1] G.R.O. 3586, dated 1/3/18.

[2] G.R.O. 3480, dated 31/1/18.

II. DISPOSAL OF OFFICERS AND OTHER RANKS CLASSIFIED CLASS "A"

(*a*) Staff, Departmental, and all other Officers extra-regimentally employed will, on being discharged Class "A" from Hospitals, Convalescent Homes, and Command Depots, be sent direct to join the unit or formation in which they were serving.

(*b*) Officers belonging to Garrison Battalions, on being discharged Class "A" from Hospitals, Convalescent Homes, and Command Depots, will be sent direct to rejoin their Units.

(*c*) Officers of the Imperial Camel Corps, on being discharged Class "A" from Hospitals, Convalescent Homes, and Command Depots, will be sent to the Administrative Centre, Imperial Camel Corps, Abbassia.

(*d*) All Officers, with the exception of those referred to above under sub-headings (*a*), (*b*) and (*c*), on discharge Class "A" from Hospitals, Convalescent Homes and Command Depots, will be sent to their respective Base Depots.[1]

Note.—Officers and Other Ranks discharged Class "A" from Field Ambulances will be sent direct to join their Units. Nominal Rolls of Officers and Other Ranks discharged from Field Ambulances direct to their Units will be sent by the O.C. of the Discharging Medical Unit to the O.C. of the Unit concerned and to the D.A.G. 3rd Echelon.

I. (*b*) All Indian Ranks and Followers will on discharge from Base or Stationary Hospitals or C.C.S.s be sent, Cavalry, R.A., S. & T., Veterinary and Remounts Depots, to the I.C.B.D., all others including Medical Details to the I.I.B.D.

N.B.—Indian Officers, Other Ranks, and Followers discharged as "A" from Field Ambulances will be sent direct to join their Units.

Details admitted to Detachment No. 5 Indian General Hospital, Alexandria, from Camp "A" will, if discharged as "A," be sent to join that camp and not to the Indian Base Depots.

III. DISPOSAL OF OFFICERS AND OTHER RANKS CLASSIFIED "B.i," B.ii," AND B.iii"

(1) All Officers and Other Ranks of Yeomanry and Infantry Units (excepting personnel of Garrison Battalions, who will be sent direct to rejoin their Units) will, if classified "B.i," "B.ii,"

[1] G.R.O. 3480, dated 31/1/18.

or "B.iii," be sent, on discharge from Hospitals or Convalescent Homes or Depots west of the Canal, to No. 800 Area Employment Company, Labour Corps, Alexandria.

(2) All Officers and Other Ranks of Yeomanry and Infantry Units (subsequent to the above proviso regarding Garrison Battalions) will, if classified "B.i," "B.ii," or "B.iii," by Medical Boards east of the Canal, be sent to their respective Base Depots.[1]

(3) All Officers and Other Ranks of arms of the service other than Yeomanry and Infantry will, if classified "B.i," "B.ii," or "B.iii," and found medically unfit to remain in employment with their Units, be sent to join their respective Base Depots, irrespective of the location where they were medically classified.

(4) Personnel attached to technical units for trade testing or to Instructional Units for training in technical trades will, if classified "B.i," "B.ii," or "B.iii," be sent, on discharge from Hospitals, Convalescent Homes, and Depots west of the Canal, to No. 800 Area Employment Company, Labour Corps, Alexandria; if classified "B.i," "B.ii," or "B.iii" by Medical Boards east of the Canal, they will be sent to the General Base Depot.

Note.—All Officers and Other Ranks classified "B" will be at the disposal of the D.A.G. 3rd Echelon.

Indian Troops

Men classified as "B" will be attached to the Indian Detail Camp, Suez, and be utilized as required under orders of the D.A.A.G. 3rd Echelon, Indian Section, subject, in the case of registered instructors and specialists, to the approval of the D.A.G./G.H.Q.

IV. DISPOSAL OF OFFICERS AND OTHER RANKS CLASSIFIED "D.i"

All officers and Other Ranks classified "D.i" will, on discharge from Hospitals and Convalescent Homes, be discharged to Command Depots.

(*a*) Officers and Other Ranks discharged from Hospitals and Convalescent Homes in and near Cairo will, if classified "D.i," be sent to the Command Depot, Abbassia.

[1] G.R.O. 3480, dated 31/1/18.

(*b*) Officers and Other Ranks discharged from Hospitals and Convalescent Homes in and near Alexandria will, if classified "D.i," be sent to the Command Depot, Mustapha.

(*c*) Officers and Other Ranks discharged from Hospitals east of the Canal will be sent to the Command Depot, Abbassia.[1]

Note.—The medical classification "D.ii" only applies to Officers and Other Ranks temporarily unfit for Class "A" or Class "B" undergoing medical treatment in Base Depots.

V. MEDICAL INSPECTION

All Class "D" Officers and Other Ranks in Command and Base Depots will, as long as they remain there, be examined once a week by the Medical Officer, who will relegate them to their original category on the completion of treatment, unless in his opinion they should be reclassified, when he will arrange for their examination by a Standing Medical Board (A./10234).[2]

Base Depots

(*a*) "D" Class Indian Ranks and Followers at the Indian Base Depots will be examined weekly for the first five weeks by a Medical Officer. If still unfit for "A" at the end of that period, and likely to continue so unfit for a considerable time, they will then be brought before a Medical Board for reclassification.

(*b*) All Officers under whom Class "B" Other Ranks are serving are responsible that all men whose paybooks do not show them as "B.i," "B.ii," or "B.iii" are medically inspected weekly with a view to their being brought before a Medical Board for reclassification. Boards for this purpose will be assembled under instructions to be issued by the D.M.S.[3]

Note.—It must be clearly understood that no Officer or soldier is to be placed in Class "B" except by a Medical Board.

All personnel whose medical category is "P.B."[4] will be examined monthly (unless such personnel are over forty-one years of age); the examination to be completed by the tenth of each month.[5]

(*b*) All Officers under whom Class "B" Indian Ranks and Followers are at present serving are responsible that these are

[1] G.R.O. 3480, dated 31/1/18.
[2] G.R.O. 3586, dated 1/3/18.
[3] G.R.O. 3480, dated 31/1/18.
[5] G.R.O. 2287, dated 19/3/17.
[4] "P.B." means Permanent Base, a term now replaced by Base "B."

medically inspected every three months with a view to their being brought before the Standing Classification Board for re-classification.

Medical Examination of Personnel belonging to Garrison Battalions

With reference to General Routine Order No. 2496 of Feb. 5, 1917, and No. 2287 of March 19, 1917 :

The attention of All Officers Commanding Units and Formations is drawn to the fact that all personnel belonging to Garrison Battalions in the Egyptian Expeditionary Force who have not hitherto been classified should be sub-classified forthwith irrespective of age.

Area Employment Companies

Men in Area Employment Companies will be examined by an R.A.M.C. Officer every three months.[1] Such men as this Officer considers should be reclassified will be referred to a Standing Medical Board.

W.O.s, N.C.O.s, and men of "B" Category transferred to R.A.F., M.P., R.E., other than Field Units, A.S.C., R.A.M.C., A.O.C., A.V.C., and A.P.C., in substitution of "A" class personnel, will be examined by Medical Boards once in three months for the purpose of reclassification, commencing from June 1, 1918.[2]

In the case of personnel between the ages of forty and forty-six reclassified "A," a certificate signed by the Officer Commanding the Unit and the Medical Officer, stating that such personnel are fit for service with front-line Units, will accompany nominal rolls rendered to the D.A.G. 3rd Echelon.[3]

VI. ESTABLISHMENT

The permanent attachment of "B" men to approved establishments on the Lines of Communication or at the Base will be sanctioned by the D.A.G./G.H.Q., only, who will notify his decisions to the D.A.G. 3rd Echelon.[4]

No Officer or Other Rank of Class "A," Class "D," or Class "B" in a Base Depot will be employed on extra-regimental

[1] G.R.O. 3802, dated 18/4/18.
[2] G.R.O. 3387, dated 2/6/18.
[3] G.R.O. 4253, dated 26/6/18.
[4] G.R.O. 3480, dated 31/1/18.

employments on the L. of C. without the sanction of the D.A.G./G.H.Q.

"B" Class personnel will be shown separately on A.F. B.213 (or A.F. B.213*a* in the case of A.S.C. units) when held in addition to War Establishment, for instance in the case of Hospitals, Base Depots, etc.

The establishment of Class "B" sanctioned will be shown in the War Establishment column and any deficiencies in the "Wanting to complete" column.

Indian Troops

The permanent attachment of "B" men to establishments on the L. of C. or at the Base, which have been approved by the D.A.G./G.H.Q. will be sanctioned by the D.A.A.G. 3rd Echelon, Indian Section.

Applications for sanction to special additional establishments of "B" personnel will be submitted to D.A.G./G.H.Q.

"B" personnel employed on authorized establishments away from Suez will, when no longer required, be returned to the Indian Detail Camp at that place.

"B" Class personnel will be shown separately on A.F. B. 213.

VII. ARMY BOOK 64

When a man has been placed in Class "B" an entry to that effect, together with the disease and date, will be made on inner page of the back cover of Army Book 64, under the record of inoculations.

This entry will be signed in full by one of the members of the Board which places the soldier in this class.

When a man who is Class "B" is reclassified "A," an entry to that effect will be made in the inner page of the back cover of Army Book 64, and signed in full by one of the members of the Board by whom the soldier has been reclassified.

Men sent to Field Ambulances, Casualty Clearing Stations. and Hospitals will take with them their Army Book 64.[1]

Indian Troops

When a man has been placed in Class "B" an entry to that effect, together with some cause of his disability and date of

[1] G.R.O. 3480, dated 31/1/18.

classification, will be made on the inner page of the back cover of his A.B. 64 (paybook) under the record of inoculations. This entry will be signed in full by one of the members of the Board which placed the man in this class.

It must be clearly understood that no Indian Officer, O.R., or Follower is to be placed in Class "B" except by a Standing Medical Board.

Steps must be taken to ensure that men sent to an Ambulance or Hospital are in possession of their A.B.s 64.

No Indian Officer, O.R., or Follower of Class "A," "B," or "D" in the Indian Base Depots or Indian Base Hospitals will be employed extra-regimentally outside these Depots or Hospitals without the sanction of D.A.G./G.H.Q.

Formations which already have a sanctioned establishment of attached "B" personnel must submit applications for further additions thereto to the D.A.G./G.H.Q. for sanction.

VIII. NOMINAL ROLLS

All Officers commanding Units and formations and all officers not serving with definite Units and formations having Class "B" personnel (Yeomanry and Infantry) under their employ who have not been transferred to Garrison Battalions or to Area Employment Companies, Labour Corps, will submit rolls of the same from time to time to the D.A.G. 3rd Echelon, with a view to transfers to Garrison Battalions or to Area Employment Companies being effected. Such nominal rolls should clearly indicate whether the men are extra-regimentally employed, or whether they are available as reinforcements for Garrison Battalions.[1]

IX. STANDING MEDICAL BOARDS

Standing Medical Boards discharge five functions, namely:

1. Classification.
2. Invaliding.
3. Medical Reports relating to Pensions.
4. Recommendations regarding appointments to Commissions.
5. Recommendations regarding repatriation of Prisoners of War.

[1] G.R.O. 3480, dated 31/1/18.

There are five Standing Medical Boards in the E.E.F., but they do not all discharge identical functions. Their location and functions are as follows:

1. Palestine L. of C. (as far as El Arish)

The above functions are discharged by this Board with the exception of Invaliding.

2. Canal Zone

The above functions are discharged by this Board with the exception of Invaliding.

3. Delta District

(*a*) At each Hospital there is a Standing Medical Board, presided over by the President Standing Medical Boards, Delta District, with two Medical Officers appointed for the purpose form time to time by the O.C. of the Unit.

The Board meets once weekly, or oftener if necessary. It recommends the classification or invaliding of cases submitted to it; the examination of applicants for commissions, when so instructed by the A.D.M.S. Delta District; and Medical reports with regard to Pensions on cases submitted by the A.D.M.S. Delta District, and classifies Prisoners of War for the purpose of repatriation.

(*b*) Boards which discharge all these functions, except Invaliding, similarly constituted and presided over by the President Standing Medical Board, Delta District, are held at Convalescent Depots, Command Depots, and various other Camps and Depots.

4. Alexandria District

Classification Boards for dealing with "B" and "D" cases are held at the Command Depot, Sidi Bishr, Reception Station, Mustapha, and Metras Camp. They are presided over by the President Standing Medical Board, Alexandria District, the other members being appointed from time to time.

Each Hospital in Alexandria, however, has its own Board for performing the work done by the Standing Medical Board in the Delta District.

5. Special Invaliding and Commissions Medical Board, R.A.F.

A special Invaliding Board sits at Mustapha to carry on in the E.E.F. the instruction of A.C.I. No. 960, dated 16/6/1917, as follows :

1. The question as to whether a Flying Officer or Observer of the Royal Flying Corps, who has been temporarily incapacitated by illness or injury, is fit to resume flying or observing, or whether he is permanently unfit for flying or observing, will in all cases, subject to the exceptions dealt with in para. 4, be left to the decision of the Special Medical Board for the Royal Flying Corps at the Air Board Office, Strand.

2. In the case of an Officer who has so far recovered that in the opinion of a Medical Board he is likely to be able to resume flying or observing within a specified time, he should be returned to light duty without flying for a period not exceeding one month. At the expiration of this period the Officer will be brought before the Special Board for a decision as to his capacity to resume flying.

3. An Officer whose condition is such that in the opinion of a Medical Board he is unlikely ever again to be fit for flying or observing will be brought before the Special Medical Board at the end of his first period of light duty, and the question of his permanent incapacity for flying or observing will be decided by the latter Board.

4. If, however, the ailment or injury is of such a trivial nature that in ordinary circumstances he would not be required to attend before a Medical Board, the above rules need not be held to apply. In such cases the Officer may be returned to flying duty without reference to the Special Medical Board.

5. When the Special Medical Board for the Royal Flying Corps has pronounced an Officer permanently unfit for duty as pilot or observer, the finding as regards flying will not be reviewed by subsequent Medical Boards. Such Boards may, however, recommend that he be again examined as to his fitness for flying duty by the Special Medical Board for the Royal Flying Corps if it is considered that his condition warrants such a recommendation, but will express no opinion of their own as to his fitness for such duty.

Officers who are unfit for flying are not necessarily unfit for general service in other respects.

6. Sick or wounded Flying Officers or Observers will be ordered to report as follows :

(i) If from overseas, to the Air Board Office.

(ii) (*a*) If away from their Unit less than 14 days, to their Unit.

(*b*) If away from their Unit more than 14 days, to their Group Headquarters, R.F.C.

The R.A.F. Commissions Board also sits at Mustapha to examine all candidates for Commissions in the R.A.F. in accordance with instructions received from time to time from the G.O.C./R.A.F. Middle East, or the Medical Supervisor, Air Board, London.

X. DUTIES OF STANDING MEDICAL BOARDS

It is clear that Standing Medical Boards are not clinical investigation agencies. They are Boards of Assessment formed to determine the fitness of a soldier for duty in terms of the evidence furnished by the Medical Officer in charge of the case. A concise clinical report should accompany each case when presented to the Board, and it should be supplemented whenever necessary by a report from the Consulting Surgeon or Physician, from an Oculist, Aurist, Neurologist, Heart Specialist, or other Expert. This information should be obtained before the case is sent to the Board, in those cases in which it is necessary to obtain it ; otherwise it involves two attendances at a Board meeting on the part of the soldier instead of one. It is the business of the Board to weigh the evidence furnished, and to make an assessment accordingly.

It must also be clearly understood that Standing Medical Boards are not bound by the opinion of specialists to whom cases are referred. A Board cannot divest itself of responsibility in making a decision, and, valuable as may be the opinion of specialists or medical officers upon individual cases, the Boards themselves are free to come to any decision they think fit in view of all the circumstances of the case.

The object of a Classification is to determine the fitness of a soldier for the various occupations to which he may be assigned. A Medical Board in endeavouring to effect this estimation will be confronted with two sets of circumstances.

A soldier may possess a definite organic and more or less measurable disability. It becomes a matter of judgment how

far this definite disability interferes with his utility, and this clearly depends on the driving force of the individual; in other words, some men will find a considerable defect giving little or no trouble, other men are overwhelmed with a very minor defect. It consequently becomes necessary for the Board to determine whether the disability is such as should be overcome by a normal man of average mentality and morale.

The following instance will illustrate:

A soldier presented himself to a Standing Medical Board. He was a healthy, well-made young man with a defect of the left foot. He stated that the left foot had been crushed on a railway ten years before. The great toe and metatarsal bone had been removed, together with the greater part of the second toe, so that the point of support of the foot was the head of the second metatarsal bone. The Board was about to mark him "B.ii" on the ground of his inability to march, when he requested to be marked "A" and said he felt perfectly fit. He was tested by a three-mile march and by a run through sand, and showed that he was quite capable of doing what was necessary. It is quite fair to say that, apart from his own determination, any set of Medical Officers would have marked him well in the "B" class.

The estimation, therefore, of the effect of a physical disability is to be co-related with some estimate of the mentality and morale of the soldier concerned.

It is evident that too much weight must not be laid on the man's own estimate of his capacity or incapacity to overcome a disability. The problem before a Board is, given a known mentality and morale in the case of a soldier, what will be the effect of associating him with other human beings who possess a normal outlook, and of subjecting him to healthy discipline.

XI. PROCEDURE ON DISCHARGE FROM HOSPITAL

Sick or wounded, who, in the opinion of the Medical Officer in attendance, and the Commanding Officer of the Hospital, are not likely to be fit for military service in any class within five months, should be brought before one of the Invaliding Boards appointed for the purpose. The Invaliding Board will, after careful examination, answer the question whether the patient is likely to be fit for any kind of military service within five months; and if the answer be in the negative, will recommend a change to England.

The members of the Boards are reminded that service in Egypt

THE FOOT OF A SOLDIER WHO WISHED TO BE CLASSIFIED "A."

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or other compassionate considerations are not to be considered by them. Their function is limited to the careful answer to the question above stated.

"*D*" *Class.*—Patients discharged from Hospital or Convalescent Depot, who are temporarily unfit for Class "A" or "B," but who are likely to be fit within five months, should be classed "D.i" and sent to a Command Depot, should graduated training be thought advisable. Men on discharge from Hospital or Convalescent Depot who still require medical or dental treatment as out-patients should be classed "D.ii." When discharged to Base or Command Depots, the Officer Commanding the Hospital or Convalescent Depot shall send with them a nominal roll and concise clinical information. These particulars will be transmitted to the Base or Command Depot through the A.D.M.S. of the District in which the Depot is situated.

"*B*" *Class.*—Men discharged from Hospital (temporarily) unfit for Class "A," but who are fit for some kind of Military Service, should be classified "B.i," "B.ii," or "B.iii," in accordance with the existing orders and practice.

This classification should be effected whenever practicable at the time of discharge from the Hospital, and at the Hospital.

XII. CLASSIFICATION BOARDS

Personnel Eligible for Classification Boards

Men not Previously Classified.—A.D.s.M.S. District may, with D.M.S.'s concurrence, hold special Boards, under the following circumstances:

Should there be an accumulation of men who have not been classified since arrival in Egypt or concerning whom there is no record available of any previous classification, this Local Board, with a Senior Officer as President, may have authority to classify such men "A" as the Board consider fit for this category. All men whose cases are regarded as doubtful, or who, in the opinion of the Local Board, belong to Class "B," will be referred to a Standing Board.

Unclassified men in the Field may, if considered fit for Class "A" duties, be classified by the M.O. i/c, date and classification being entered in A.B. 64.

Any previously unclassified man found unfit for Class "A" should be referred to a Standing Classification Board.

Men in Garrison Battalions not previously classified must be submitted to Boards and sub-classified irrespective of age.

"D" Class Personnel

"D" Class Officers and Other Ranks in Command and Base Depots are examined once a week by the Medical Officer, who relegates them to their original category on the completion of treatment, unless in his opinion they should be reclassified when he arranges for their examination by a Standing Medical Board.

"D" Class Indian ranks and followers at the Indian Base Depots are examined weekly for the first five weeks by a Medical Officer. If still unfit for "A" at the end of that period, and likely to continue so unfit for a considerable period, they are then brought before a Medical Board for reclassification.

A Standing Classification Board may, however, call for the presentation of all or any "D" Class at any time this may appear to be desirable. At each sitting of a Board the Officer in medical charge of the case should be present if possible. A short report in writing should be furnished for each case brought before a Board.

"B" Class Personnel

All "B" Class personnel (unless such personnel is over forty-one years of age, and other than those in Area Employment Companies or transferred to R.A.F., M.P., R.E. other than Field Units, A.S.C., R.A.M.C., A.O.C., A.V.C., and A.P.C., in substitution of "A" Class personnel) are examined once a month by the Medical Officer of the Unit. If the M.O. of a Unit is of opinion that any change of Class is desirable, he presents such cases at the next sitting of the Standing Classification Board. The M.O. concerned should be present at the sitting of the Board, or, if that be impossible, should furnish his information in writing.

Medical Officers attached to Garrison Battalions will keep nominal rolls recording the results of the monthly inspections, showing in every case whether the man is:

(*a*) Recommended for transfer to a higher category.

(*b*) Retained in existing category.

(*c*) Referred to a Board for transfer to a lower category.

A note as to progress, or the reverse, should be made in each case. In this manner a permanent record of these inspections

and their results will be available, and rolls should be submitted to the A.D.M.S. for perusal after each inspection.

It is understood, however, that a Standing Classification Board may call for the presentation of any "B" Class men, if at any time it be thought necessary to do so.

W.O.s, N.C.O.s, and men of "B" Category transferred to the R.A.F., M.P., R.E. other than Field Units, A.S.C., R.A.M.C., A.O.C., A.V.C., and A.P.C., in substitution of "A" class personnel, and men in Area Employment Companies will be examined by an R.A.M.C. Officer every three months. Such men as this officer considers should be reclassified will be referred to a Standing Classification Board.

Men in Area Employment Companies placed in Category "A" will be transferred to a first-line unit.

XIII. PROCEDURE PRELIMINARY TO A MEDICAL BOARD

It should be clearly understood that cases cannot be presented to any Invaliding or Classification Board without a definite clinical report from a Medical Officer. It is this report which forms the basis of the proceedings of the Board, and the facts it embodies are the cause of the Board's action.

Nominal Rolls of Officers and other ranks presented to a Medical Board should be made out on the Special Classification forms (A.P. & S.D. Alexandria/$\frac{4199}{50025A}$ A. 7.18.20 M. R.B.).[1]

In the case of Officers these forms should be made out in quadruplicate, in the case of W.O.s, N.C.O.s, and other ranks, in triplicate.

In filling in the forms, some points demand attention:

When preparing nominal rolls for a Classification Board the columns "Disability," "New Classification," and "Clinical notes" are to be left blank for the remarks of the Board. The remaining columns are to be completed in every detail by the Medical Officer preparing the roll.

The clinical evidence should be presented on a separate sheet.

Initials of Officers and Other Ranks must always be given, as well as Unit, and in the case of Other Ranks regimental number.

Names of Officers and Other Ranks should be recorded on separate sheets.

[1] See page 95.

British, Colonial, and E.L.C. Officers or men must never be on the same sheet.

Nominal rolls should be prepared by arms, *i.e.* Personnel of Infantry, Yeomanry, R.A., R.E., etc., should appear on different sheets. If possible, Infantry should be shown by divisions.

The age stated should be the age as given in the paybook of the soldier, and not his age as stated by himself.

Care should be taken to inquire from him the nature of his occupation in civil life.

The disability must be clearly defined, and the terms used should, whenever possible, be those of the Official Nomenclature of Diseases.

XIV. PROCEDURE AT MEDICAL BOARDS

In the case of Officers, before proceeding to classification, the Standing Medical Boards must ask the Officer whether he has been previously Boarded in Egypt, and if he answers in the affirmative the Board will be postponed till the receipt of the proceedings of the previous Board have been obtained.

In order to avoid delay the proceedings should be asked for by wire.

A Board should not in general proceed with the business of classifying a man, unless his paybook is produced and examined, In the event of a new paybook being issued, the old entries relating to Classification should be entered in the new book.

The classification recommended by the Board, the nature of the disability, and the notes contained in the right-hand columns should be entered in the man's (paybook) A.B. 64, after approval of the Board's recommendation by the A.D.M.S. of the District.

In those cases in which it is undesirable that the man should be aware of the nature of this clinical information, it can be forwarded to the A.D.M.S. of his Division if he belongs to a Division after Boarding, but a man of "A" class who is Boarded "B" class ceases to belong to a Division, and must be allotted to a fresh Unit. To meet this case, the D.A.G. 3rd Echelon has undertaken to forward any information sent to him to the Officer Commanding the Unit to which such a man will ultimately be allotted.

Too much stress cannot be laid on the importance of the accurate entry in a man's A.B. 64 of this clinical information. Nearly all the difficulties which have arisen in connection with

multiple Boards, and of overlong stay in Hospital, have arisen from failure to pass clinical information on with the soldier. In its absence, each Medical Officer has to begin the work over again.

The following instance is worth narration as showing what can occur :

A soldier suffering from hysterical protrusion of the abdomen was classed " A " and sent up the line, a full report being sent to the A.D.M.S. of the Division. Before he reached the Division a Medical Officer saw him and sent him into Hospital, whence he was returned to the Base to a Hospital he had not been in before. He was again brought before two Medical Boards, and classed " A " and sent to a Camp. After some stay in the Camp, a newly arrived Medical Officer saw him and returned him to Hospital for constipation. He was then sent to Helouan for mechanical treatment, where he was again seen by a Medical Officer who was unaware of the former proceedings. This proceeding occupied some months, and might have been obviated if it had been possible to see that full clinical notes accompanied him at each stage of the journey. Concise entries in A.B. 64 offer the simplest means of obviating this difficulty.

It has been brought to notice that in certain instances men belonging to administrative branches of the Army have been placed by Travelling Medical Boards in Category " A " subject to their being employed in an administrative unit.

It must be clearly understood that no man is to be placed in Category " A " unless he is fit for general service in any unit or arm to which he may subsequently be posted or transferred, and that limitations such as that quoted above are not to be taken into consideration.

In all cases of classification the MEDICAL CLASSIFICATION FORM should be completed and signed by the Members of the Board. One copy must be sent to the D.D.M.S. Corps, or A.D.M.S. District, one to the D.A.G. 3rd Echelon, and one to the Officer Commanding the Unit. In such Districts or Corps where the A.D.M.S. or D.D.M.S. wish to ratify the proceedings, the latter two copies cannot be dispatched until formal approval has been given. The decision of the Board, whether " A," " B," " C," or " D " together with the disability should be entered in the man's A.B. 64.

Examination at Base and Command Depots

As laid down in General Routine Order No. 3480, dated 31/1/1918.

Copies and extracts of Medical Boards affecting the A.I.F. or N.Z.E.F. should be sent to H.Q.A.I.F., or N.Z.E.F., Cairo, as the case may be (D.M.S. 3273/1/G, dated 9/11/17).

XV. DISPOSAL OF OFFICERS AND MEN AFTER BOARDING

The regulations governing the disposal of Officers and men are laid down fully in the précis of G.R.O.s and need not be recapitulated here. One or two cases, however, require special attention and are detailed below:

The Case of Men classified "A" sent to Front Line and returned

The following memorandum establishes a procedure for the disposal of such cases:

No. 2354/G, dated 11/7/17.

It has been found necessary to establish special Classification Boards. Men classed by these Boards as "A" are sent to the front-line Units, and, as far as possible, the Board sends notes of each man so classified to the M.O. of the Unit to which the man belongs.[1]

Nevertheless the M.O.s of Units send these men back for the disability which, in the opinion of the Board, does not preclude them from being Class "A." Thus it comes about that there is a continual traffic up and down the line of these men. In order to reduce this useless up-and-down traffic to a minimum would you please cause all M.O.s of Units to send in a full detailed statement with each man sent sick because of a disability which they consider unfits him for Class "A." On admission to a Field Ambulance the O.C. of the Field Ambulance will record his opinion on the statement furnished by the M.O. i/c Unit, and finally the man will be brought before the A.D.M.S. Division, who will decide as to the necessity for evacuation, and in the event of evacuation will give clear reasons for his opinion that the man is unfit for Class "A" and will record this opinion on the statement furnished by the M.O. i/c Unit. This document

[1] D.M.S./E.E.F. 2354/G, dated 11/7/17.

will accompany the man until he next appears before a Classification Board. In the event of a man being with a non-Divisional Unit, a similar procedure will be adopted by the A.D.M.S. of the area in which the man's Unit is located.

This recommendation from the Front is usually referred to as the TRIPLE CERTIFICATE.[1]

The triple certificate applies equally to Officers and other Ranks and to Indian troops sent from Divisions.[2]

PERSONNEL BETWEEN THE AGES OF FORTY AND FORTY-SIX RECLASSIFIED "A"

In the case of personnel between the ages of forty and forty-six reclassified "A" a certificate signed by the Officer Commanding the Unit and the Medical Officer, stating that such personnel are fit for service with front-line Units will accompany nominal rolls rendered to D.A.G. 3rd Echelon.[3]

XVI. STANDARDS OF CLASSIFICATION ADOPTED IN SPECIAL DISEASES

The following notes, based on Army Regulations or on a considerable experience of Standing Boards, are furnished as a general guidance to Medical Officers:

STANDARDS OF VISION FOR OFFICERS, RECRUITS, AND SERVING SOLDIERS

A.C.I.s 1367 of 1916, 211, 1371 (para. 1) and 1476 of 1917 are hereby cancelled and the following substituted:

1. OFFICERS (PERMANENT, TEMPORARY, SPECIAL RESERVE, AND T.F.)

(1) A candidate for a commission will be considered fit if his vision, "without the aid of glasses, is not less than 6/60 with each eye, provided that with the aid of glasses, if necessary, his vision is not less than 6/9 in one eye (R. or L.) and 6/18 in the other."[4]

(2) A candidate for a commission will be considered fit if he has one eye (R. or L.) with vision of not less than 2/60 and with a good field of vision as tested by hand movements, provided

[1] D.M.S. 2354/425/G, dated 9/4/18.
[2] D.M.S. 4643/15/G, dated 8/6/18.
[3] G.R.O. 4253, dated 26/6/18.
[4] A.C.I. 421, dated 2/4/18.

that "his vision in the other eye is 6/6 or not less than 6/12 without glasses and capable of correction to 6/6 with the aid of glasses."

2. Recruits

Instructions to Examining Medical Officers

When necessary to retest the vision of a recruit the following procedure will be adopted:

If a recruit can read without glasses not less than 6/12 with each eye, he may be accepted for Category "A" without an examination by an Ophthalmic Specialist.[1]

If the vision is below this standard the recruit shall be sent for examination to an Ophthalmic Specialist.

Instructions to Ophthalmic Specialists

Category "A."—A recruit will be considered fit for Category "A" if his vision, "without the aid of glasses, is not less than 6/60 with one eye (R. or L.) and not less than 2/60 with the other, provided that, with the aid of glasses if necessary, his vision is not less than 6/12 with one eye, and that both eyes have good fields of vision as tested by hand movements."

Category "B."—"B.i." A recruit whose vision is not equal to the standard laid down for Category "A" will be considered fit for Category "B.i" if his vision, "without the aid of glasses, is not less than 3/60 with the better or only eye, provided that with the aid of glasses his vision is not less than 6/18 with one eye."

"*B.ii.*"—A recruit whose vision is not up to the standard laid down for Category "B.i" will be considered fit for Category "B.ii" if his best obtainable vision with the better or only eye (with or without glasses) is not less than 6/60.

Men in the Labour Corps whose best obtainable vision, aided if necessary with glasses, is less than 6/24 with the better or only eye will be considered unfit for dangerous employment such as dock labour, railway shunting, etc.[2]

"*B.iii.*"—The standard of vision for clerks will be the same as for "B.i," while that for other occupations referred to in paragraph 6 B.iii of A.C.I. 1606 of 1917, viz.:

Storemen, batmen, cooks, orderlies, sanitary orderlies, or skilled tradesmen—will be the same as for "B.ii."

[1] A.C.I. 421, dated 2/4/18.

[2] A.C.I. 421, dated 2/4/18.

Note.—(1) A man may be passed into category "B.i," "B.ii," or "B.iii" if one of his eyes has been lost or is completely blind, provided that the remaining or better eye is up to the required standard, and has a good field of vision as tested by hand movements.

(2) No man will be accepted for any form of military service with a lower standard of vision than that laid down for "B.ii."

3. Serving Soldiers

In retesting the vision of serving soldiers the standard will be the same as for recruits, but men who have been found capable of carrying out their duties efficiently need not necessarily be placed in a lower category on account of their eyesight not being equal to the standard laid down for the category in which they are serving.

4. Commissions in the R.A.F.

The standard of vision set down for Candidates for Commissions in the Flying Corps is as follows:

1. The standard vision for Pilots, Observers, and Balloon Officers will in future be as laid down hereunder:

	Without Glasses.	With Glasses.
Pilots:		
Better eye . .	6/12	6/6
Worse eye . .	6/18	6/12
Observers and Balloon Officers:		
Better eye . .	6/18	6/9
Worse eye . .	6/18	6/12

Correcting glasses must be obtained when necessary, and be adapted for wear beneath goggles.

Good colour sense must be insisted upon, and for the purpose of testing this the Edridge Green Lamp will be used; doubtful results being confirmed by the Edridge Green Bead Test.

2. Candidates having more than two dioptres of hypermetropia will not be accepted as Pilots, but this condition need not disqualify them from acting as Observers or Balloon Officers.

For practical purposes the condition may be judged by testing the vision with a + 2. O.D. Lens. A candidate should not then be able to read the test type lower than 6/12. (A.C.I. 1016 of 1917.)

5. Tank Corps

1. *Officers.*—Candidates for Commissions in the fighting personnel of the Tank Corps will be accepted—

(*a*) If the vision is in each eye *without glasses* not less than 6/18, or

(*b*) If the vision *without glasses* in one eye (R. or L.) is not less than 6/9 and in the other not less than 6/60.

2. *Other Ranks.*—As laid down for Officers in sub-paras. (1) (*a*) and (*b*).

6. Drivers in the R.A., R.E., A.S.C. (M.T.), & A.S.C. (H.T.)

Men will only be accepted as drivers in the R.A., R.E., A.S.C. (M.T.), and A.S.C. (H.T.) if their vision *without glasses* is not less than 6/18 in one eye and not less than 6/60 in the other, and provided that they have a good field of vision in each eye as tested by hand movements. (A.C.I. 664 of 1918.)

7. Loss of One Eye (Officers)

By A.C.I. 1587, dated 14/8/1916 the loss of an eye is not considered as constituting a bar to fitness for general service. This means that Officers who have lost an eye will be classed "A" unless there is some other disability.

8. Trachoma

1. In future soldiers suffering from undoubted Trachoma will be discharged from the service as soon as the disease is definitely diagnosed.

2. When a man suffering from Trachoma is about to be discharged from the service, a notification of the facts will be sent to the Civil Medical Officer of Health of the District in which the man intends to reside.[1]

This notification will be in addition to that referred to in A.C.I. 449 of 1917 which is made on A.F. W. 3555 to the Local War Pensions, etc., Statutory Committee.

9. Hearing

So far as Hearing is concerned, methodical standards cannot be applied with the same degree of certainty as in the case of vision, but the following principles will serve for guidance:

The possession of one perfectly sound ear is quite sufficient

[1] A.C.I. 574, dated 4/4/17.

to fit a man for general service. The case is comparatively simple, because the possession of one perfectly sound ear with total deafness in the other ear is a most uncommon combination.

The possession of hearing somewhat less than normal in both ears well permits of classification "A."

There are practically three standards of hearing in use—

(*a*) Ordinary good hearing warrants classification "A."

(*b*) Hearing short of this standard but sufficiently good for Garrison Battalion Guard work warrants classification B.i Front Line, B.i L. of C., or B.ii L. of C. The duties in these three categories so far as hearing is concerned do not differ, and the classification B.i Front Line can be made in every instance when there is no other disability.

(*c*) If the man is so deaf that he is not fit for Garrison Battalion Guard work he must be classed B.iii L. of C.

Otitis Media is not a bar to general service unless it is intractable and profusely purulent, an uncommon condition. Total Deafness warrants the adoption of Class "B.iii" A totally deaf man has made an excellent hospital orderly.

10. Teeth

Speaking generally, dental troubles are not a bar to General Service. It is a practice of the Boards by arrangement with the Consulting Dentist E.E.F. to recommend patients "for Dental Treatment" where (1) the man is "A" Class or (2) "B" Class and suffering from impaired health in consequence of dental defect. The dentist to whom the case is referred then uses his judgment as to the best technical methods to be employed.

Men who have had a number of teeth extracted and require dentures must wait a definite though varying period for the absorption of the alveolus which always occurs if a tooth or teeth are extracted; such men should be marked B. i or B.ii according to other indications present for the necessary period of waiting, which in most cases should not exceed one month.

These men should be examined by the dental officers once a week and lists of such cases sent to Presidents of Boards, giving the dates when the mouths will be ready for the insertion of dentures.

11. Varicocele

Varicocele is certainly never a disability, as suspensory

bandages are available, and there is no proof that Varicocele produces anything worse than a Transient Neuralgia.

12. Hernia

Hernia is regarded as a bar to general service at present, and men suffering from Hernia are fitted with trusses and classified "B.i" (L. of C.). This procedure does not necessarily hold good in the case of Officers. Clear definition, however, is re-required as to what constitutes a Hernia, and the practice has been to describe as Hernia only cases in which the Intestine or Omentum has definitely entered the canal and remained there; cases of men who have a protrusion on coughing only have been definitely ruled out as not possessing a Hernia.

Cases suitable for, and who consent to undergo, operation are not fit for full service for 3½ months after operation, and consequently require marking D.i or D.ii for a definite period when convalescent.

13. Nervous System

A large number of men complain of headaches, giddiness in the sun, and nervousness. It has been the object of the Board, in such cases, to ascertain whether there is any definite evidence of Neurasthenia, and stress is laid on two points,—the exaggeration of the knee-jerks and tremor of the tongue. Tremor of the limbs can be simulated; tremor of the tongue cannot. If a man is definitely and genuinely neurasthenic, he is better classed "B" and given steady work at the base for a time. It is in such cases that a Garrison Battalion acts as a Therapeutic Agency. The "D" classification has not hitherto been successful in such cases.

Similar observations apply to cases of pronounced Hysteria, which are best handled in much the same way.

Hysterical Aphonia is not uncommon. If it does not give way promptly to local treatment, such men are better classed "B" and given steady manual work, little or no notice being taken of the lack of voice. Recovery is usually speedy.

14. Shell Shock

Shell Shock will be included in the revised nomenclature of diseases, and I am to request that only cases in which there is evidence of direct contact with the effects of explosion, although

not producing visible wound (as, for example, cases which have been buried or blown up by explosion), will be regarded as "shell shock (wound)." No diagnosis of this kind will be made, however, until the evidence as to direct contact with an explosion has been obtained from the Officer Commanding the man's unit, or other responsible witness.[1]

Other cases of so-called Shell Shock symptoms or nervousness will be classified in accordance with the nomenclature of diseases, *e.g.* Neurasthenia, Hysteria, or in such other manner as meets the particular case.

Cases of "Shell Shock" will only be reported as wounded (Shell shock) when the O.C. of a STATIONARY or GENERAL HOSPITAL has notified the Unit in the Field that this should be done, as laid down in the following paragraph.

The disposal and classification of Officers and Other Ranks who, without visible wounds, have become non-effective from physical conditions, claimed or presumed to have originated from the effects of British or enemy weapons in action, will be governed by the following regulations:

The M.O. of a Unit or the O.C. of a Medical Unit who in the first instance deals with the case coming into the above category will not record any diagnosis. The case will be disposed of in the first instance as "Sick, admitted to Hospital," and the Medical Officer will enter on the Field Medical Card, or other transfer papers, the letters "N.Y.D." ONLY, and note any definitely known facts as to the true origin or the previous history of the case.

The responsibility for the FINAL diagnosis will rest with the O.C. of the FIRST STATIONARY HOSPITAL or GENERAL HOSPITAL to which the Officer or man is admitted.[2]

The Officer will INFORM THE O.C. THE UNIT to which the Officer or man belongs in cases where the diagnosis arrived at is "Shell Shock."

O.C.s will in such cases return the officer or man as "Wounded, (Shell Shock) previously reported sick, admitted to Hospital."

In no circumstances will the expression "Shell Shock" be made use of verbally or be recorded in any Regimental or Casualty report or in any hospital or other document except in cases classified in accordance with the above.

[1] W.O. letter 24/Gen. No. /5425, A.M.D. (2), dated 21/3/17.

[2] G.R.O. 346, dated 17/10/17

15. Epilepsy

Cases of undoubted Epilepsy where fits are not frequent are boarded "B.iii." Where fits are increasing in frequency the cases are best invalided to England.

16. Pulmonary System

A common defect is Chronic Bronchitis, with and without Asthma. When this results in definite Dyspnœa, the "B" classification has generally been adopted. It should be borne in mind that these men when examined exhibit physical signs of varying description. Rhonchi may be present in the morning, and absent at midday, and a broad survey of each case becomes requisite.

17. Tuberculosis

Cases will be referred to in the invaliding section.

18. Vascular System

The commonest cause of disability is that classed as D.A.H., which is so well-known to all Medical Officers. It includes so many diverse conditions that it will be impossible to refer to it at any length in this connection. There are now special arrangements made for these cases in Cairo and Alexandria so that they can be examined by specialists and subsequently classified by Boards.

Cases of D.A.H. are best classified Debility, Tachycardia.

Valvular Disease of the Heart almost invariably warrants placing the soldier in the "B" class, although there have been men with Mitral Incompetence, well compensated, who played an excellent game of football, but nevertheless, in the opinion of the Heart Specialist, were not fit for service in the front line.

19. Renal System

It need hardly be said that cases which have recovered from Nephritis are better classed "B" and kept at the Base for a substantial period.

Cases of Bilharzia are either classified "B.iii" or in exceptional cases recommended "Change to England." As "B.iii" men they do very well, but if called on to march or do severe physical work the symptoms usually become aggravated.

Cases of Enuresis where definitely proved require some consideration. The majority of surgeons think they should be classed "A" if they are otherwise fit.

20. Digestive System

Cases of Chronic Intestinal infection or Chronic Gastritis form a class which, unlike most of the other diseases, do better in Great Britain than in Egypt, and the Boards have felt disposed in severe and definite cases of the kind to recommend "Change to England."

In the case of Debility after Dysentery, service at the Base for some months is frequently indicated, and consequently classification "B."

21. Locomotor System

The cases falling under this heading are perhaps the most numerous with which the Boards have to deal, and they offer most diverse problems. We propose to deal with them seriatim.

The loss of an arm in the case of an Officer does not constitute a bar to general service, *i.e.* Class "A," consequently he must be marked "A" if the loss of the arm is the sole disability.

In the case of the men, a Board has taken the following view:

If the man is right-handed and has lost the right arm, and consequently re-education is necessary, he is better sent to England.

If he has lost the left arm and is right-handed, or vice versa, he is fit for "B.iii," other things being equal.

There are, however, cases where a man who retains a limb is worse off than if he had lost it. Such cases are the Flail arm, Drop Wrist, and other results of nervous injury; also cases of Ankylosis of both Shoulder and Elbow Joints of such a nature that a fall would immediately cause fracture. The view taken is that these cases are better transferred to England.

Some special attention must be given to Ankylosed Joints. In the opinion of surgeons, certain degrees of Ankylosis are not a bar to Class "A" in all cases, but each case requires special investigation.

The loss of a finger is not a bar to Class "A."

The total loss of both the Index and Middle finger of the right hand is a bar to Class "A."

The possession of a stiff finger is not a bar to general service, but the possession of a contracted finger may be. A rifle may be

well handled by a man with a stiff finger, but it cannot be handled by a man with a contracted finger.

Officers.—From the foregoing, it will be quite obvious that if the loss of an arm is not a bar to general service in the case of Officers, there can be very few defects of an arm which can constitute a reason for classing an Officer "B."

The Hip Joint.—Cases of Hip-joint Disease are not very common and have invariably been investigated by X-ray photographs. Without such an examination, an accurate assessment is difficult to effect.

Knee Joint.—A large proportion of the Knee-joint cases seen in Egypt are due to football and in too many cases necessitate classification in the "B" class.

The group of cases included under Flat Feet, Hallux Valgus, Hallux Rigidus, Corns, and Pes Cavus constitute a very common disability. They often occur in men who are otherwise perfectly fit in every respect, and give rise to great difficulty in classification. They require some little consideration.

In the opinion of some surgeons, Flat Foot is not so important as Hallus Rigidus, and right-angled contraction of the ankle. Mere Flat Foot without eversion, with a good flexible great toe and an ankle which can be flexed to practically a right-angle, is really no disability. The development and tone of the calf muscle should also be taken into account in these cases.

Flat feet should not be regarded as a disability unless accompanied by eversion. The so-called flat foot of the sculptor is of little importance.

The attention of recruits and serving soldiers should on no account be called to this condition unless they themselves bring it to notice.[1]

The general practice adopted by the Boards has been as follows:

Flat Feet in the slighter cases, without eversion, is not a disability.

Flat Feet in its ultimate stage, with perhaps some bony deformity but without eversion, is not a disability.

Flat Feet with eversion and notching of the tendo Achilles usually warrants inclusion in the "B" class.

The Boards have seen ploughmen and farmers with marked Flat Feet and splendid physique who are sent down the line

[1] W.O. letter 121/Medit. 597 (A.M.D. 2), dated 25/5/16.

because they cannot march far, and have consequently been compelled to include such men in the "B" class.

Hallux Rigidus unless marked is not a disability.

Hallux Valgus with Bunions may be a disability, but a case occurred recently where the Board was about to mark a case with Hallux Valgus without bunions "B.i" when they were informed that the man was an excellent footballer. It does not do to infer lightly that it is a disability, and all the collateral evidence available is required.

Pes Cavus is only a disability when quite definite and well marked. Some surgeons take the view that it is very rarely a disability, basing their opinion on their experience in civil practice.

Varicose Veins of the Leg.—The Boards have seen magnificent specimens of men with an enormous development of Varix, who stated that the veins never gave them much trouble when doing severe manual work. Other men, with trifling Varix, complain of swelling when standing or walking. It has been the practice to send these men for a walk or put them on guard, and ascertain definitely what degree of swelling did occur. In general, a moderate degree of Varix is no bar to service.

A distinction should be made between veins which are dilated and veins which are Varicose. Professional runners and nurses frequently suffer from Varicose veins.

Many of the cases would be benefited by the use of puttees rolled not too tightly and fastened below.

22. Myalgia

This condition gives more difficulty to the Boards than any other disability complained of, and necessitates a searching clinical examination.

23. Malaria

Malaria cases are now treated as other medical conditions, except that cases of Chronic Recurrent Malaria are boarded and may be classed "B.i" "B.ii" and "B.iii" Egypt for a period.

XVII. INVALIDING BOARDS

Army Forms in Use in Connection with Classification and Invaliding

The principal forms used are:

B. 179, which is employed whenever an N.C.O. or man is recommended for "Change to England."

A. 45, which is used whenever an Officer is recommended for "Change to England."

A. 45*a*, which must be filled up before the discharge from hospital of an Officer who has sustained a wound, accident, or injury in action.

A. 45*b*, which must be filled up before leaving hospital whenever an Officer has sustained a wound, injury or accident, on duty but NOT IN ACTION.

B. 183. In the case of those of unsound mind who are recommended for "Change to England."

A. 45 (REVISED). In the case of Nurses, this form will be used.

In filling up Form B. 179 for cases recommended for transfer to England a number of instructions must be borne in mind:

The Board is not responsible for the statements made by the Medical Officer. It can, however, amend the diagnosis, and it can express its disagreement with the notes of the M.O.

A disease cannot both be caused and aggravated by Active Service, because the information is furnished for pension purposes and the highest grade is granted for causation.

Pensioners are not to be questioned as to the amount of their actual earnings.

It has been brought to notice that Medical Boards, when assessing the physical disablement of soldiers about to be invalided, or of pensioners who are being examined for reassessment of their pensions, are in the habit of making inquiries as to the actual earnings of the pensioners. This is contrary to the present policy.[1]

In no cases are men to be questioned as to the amount of their earnings.

When the replies to questions 9, 10, and 11 are based on the man's own statement, the words "Man's statement" should invariably be inserted.

The Ministry of Pensions has called attention to the glaring discrepancies frequently noticed between the replies to questions 13 and 25.

If the reply to question 21 is in the negative, question 22 should invariably be answered, as otherwise further reference and unnecessary delay is involved.

Assessment of incapacity in reply to question 25 should always be in percentages of disablement in accordance with the

[1] A.C.I. 1615, dated 27/10/17.

instructions on the form, such terms as "Not applicable," "The same as on enlistment," "Not lessened since enlistment," "Nil due to service," are not to be used, as they do not help in dealing with the case from the financial point of view.[1]

It is desirable that Medical Boards should recommend institutional treatment in every case of loss of sight when the man has no useful vision.

Bronchitis, Pleurisy, Pneumonia, Rheumatic Fever, and Nephritis are only to be regarded as caused by active service if they are due to proved exposure. If necessary this evidence is to be obtained from the O.C. Unit to which the man belongs. Duty at the Base or on L. of C. can but rarely be regarded as either cause or aggravation by service. If the foregoing principles are borne in mind the answer to the question should present no difficulties.[2]

With regard to Diphtheria, it is not to be lightly assumed that the liability thereto is as great on active service during an outbreak as in civil life, and members of Boards will therefore carefully weigh the question before attributing it to active service.

Officers and Soldiers Invalided for Tuberculosis of the Lung

1. As it is found that the wording of A.C.I. 1108 of 1917 is liable to be misunderstood, the following will be substituted for the instruction which is hereby cancelled.

2. Owing to the difficulty of deciding in the case of Officers invalided and soldiers discharged on account of tuberculosis of the lung whether or not the disability is attributable to or aggravated by military service, and in order that a uniform procedure may be followed by Medical Boards when dealing with such cases, it has been decided that the following principles should be adopted:

(*a*) In all cases in which the Officer or soldier has developed the disease during service overseas, it will be considered as attributable to or aggravated by military service.[3]

(*b*) In other cases, unless the Board are satisfied that phthisis was present previous to the man's enlistment or (if he did not serve in the ranks) to the Officer's commission, and that it was

[1] A.C.I. 1475, dated 26/9/17.
[2] D.M.S./G.H.Q./E.E.F. 3721/9S, dated 3/1/18.
[3] A.C.I. 1671, dated 10/11/17.

not aggravated by military service, it should also be considered as attributable to or aggravated by military service.

Military Orthopædic Cases

Military Orthopædic cases will be held to include:

1. Derangements and disabilities of joints, including Ankylosis.
2. Deformities and disabilities of feet, such as Hallux Rigidus, Hallux Valgus, Hammer toes, metatarsalgia, painful heels, flat and claw feet.
3. All malunited and ununited fractures. All fractures of the femur.
4. Cases of nerve-lesion requiring operative or other treatment.
5. Cases requiring tendon transplantation.
6. Cases requiring surgical appliances.[1]

Military Orthopædic cases when being invalided to England will be specially labelled in order that they may be suitably distributed on arrival. (W.O. letter 24/Gen. No./4843 A.M.D. (2), dated 30/8/1917.)

Jaw and Limb Cases among New Zealand Soldiers

Bad jaw cases and badly damaged limb cases that can be improved by special treatment which is available in England and not in New Zealand are to be invalided to England in order that they may receive such special treatment.

Headquarters N.Z.E.F. in Egypt, W. 28, dated 25/5/1918.

Wounds or Injuries sustained in Action (Officers)

With reference to Articles 641 to 647 of the Royal Warrant for Pay 1914 will you please arrange for all Officers who sustain wounds or injuries in action to be examined by a Medical Board as soon as it is considered that a true estimate of the wound or injury can be determined.[2]

Proceedings to be prepared on Army Form A 45*a* and forwarded to this office in duplicate. The instructions on the back of this form must be strictly adhered to.

These Boards should only be held in hospitals in Cairo.

[1] A.C.I. 1314 of 1917.

[2] D.M.S./G.H.Q./E.E.F. 2250 G, dated 1/6/17.

SICK LEAVE OF Q.A.I.M.N.S. RESERVE, T.F.N.S. AND V.A.D. AND SPECIAL PROBATIONERS EMPLOYED ON NURSING DUTIES

The revised A.F. A 45 will be used to report proceedings of Medical Boards on nurses and probationers, but Categories 2, 5 (*b*), 6 (*a*) and (*b*), and 7 will be struck out.[1]

XVIII. COMMISSIONS

Applicants for Commissions will be examined in accordance with the procedure laid down in the regulations for the R.A.M.C., due regard being paid to the following Army Council Instructions :

1. During the period of the present war, officers acting on general service, who have proved their physical fitness by active service in the field, will not be required to undergo further medical examination when recommended for permanent commissions.

2. Similarly, Warrant Officers, N.C.O.s, and men on general service recommended for commissions on account of their aptitude for military work in the field, who have proved during their service in the field that they are physically fit to perform the duties which devolve upon a soldier on active service, may be accepted without further medical examination.[2]

3. Officers and men will not be recommended who are obviously physically unfit for general service.

4. In doubtful cases a medical examination may be called for.

[1] A.C.I. 1654, dated 6/11/17.
[2] A.C.I. 1922, dated 19/10/16.

CHAPTER V

BOARDING SYSTEM

As time passed the functions of the Standing Medical Boards widened. They became Boards of Classification, Boards of Invaliding, the Commissioners of Pensions referred cases to them for report, applicants for Commissions came under their cognizance, and finally it was decided that the Boards should investigate the physical condition of all prisoners of war who were to be repatriated. The latter function became a most extensive one, as the figures quoted later will indicate; but in addition to these duties, yet another function made its appearance as the war dragged on. People in England, apparently through Members of Parliament in many cases, wrote to the War Office stating that a soldier in Egypt was reported to be in a desperate condition. His sight was being ruined by the sun, or his health by the climate, as the case might be. These statements reached Egypt through the usual channel, and a Medical Board was then held on the soldier. Inquiries of this kind took up a good deal of time before the war ended. It will be seen, therefore, that the Standing Medical Boards were now occupied with six distinct functions: Classification, Invaliding, Pensions, Commissions, Repatriations, and Special Inquiries.

The work had become greatly extended during 1917 after the visit of the Inspector of Man Power, when

substitution was introduced on an extensive scale—that is, the fit men on the Lines of Communication were replaced by the partially unfit—and the pressure on the Boards became very great indeed; at the end of 1917 the D.M.S. estimated that directly or indirectly a division had been added to the Force in the E.E.F. by the work of the Standing Medical Boards. As the development of the man-power problem continued, all the garrison battalions were combed out twice—that is to say, they were examined twice with a view to re-classifying their members, and a large number of men in the categories of "A" and "B.i Front Line" were obtained from them. Furthermore all fresh drafts of garrison battalion personnel from Great Britain were classified on arrival. Of both these proceedings there is a good deal to say. In one garrison battalion 800 strong, no less than 400 men (approximately) were classed "A," and a further number were classed "B.i Front Line." It will be readily understood that so drastic a combing out of the battalion did not excite the enthusiasm of the battalion commander nor of his staff, though they loyally supported the finding of the Board.

The details given in the table on page 66 tell their own tale.

In the course of these investigations many perfectly fit men were found who stated that they had never been previously examined, but had been incorporated direct from the Special Reserve. In very many cases no record of previous classification could be found—in fact, it was perfectly evident that no careful scrutiny had been made. When permission was given in 1917 to enter the finding of all Medical Boards, with clinical notes, in the paybook (A.B. 64), these irregularities

RECLASSIFICATION OF A GARRISON BATTALION

January 23 *to March* 30, 1918

Presented for reclassification	827
Deferred as stated below	48
Reclassified, as below	779

Disability.	Raised to "A."	Raised to "B.I.F.L."	Confirmed "L. of C." "Bi or B.li"	"B.lli."	Total.
None	281	These men were marked "No Apparent Disease"			281
Age	—	24	91	1	116
Feet	21	6	20	—	47
Debility	9	5	25	1	40
D.A.H.	2	2	29	2	35
Hernia (and Hy.)	5	—	28	—	33
Bronchitis	2	1	27	—	30
Vision Def.	5	8	16	—	29
Organic Disease of Heart	—	2	24	2	28
G.S.W. (old)	21	2	5	—	28
Miscellaneous	4	1	14	3	22
Varix	9	1	5	—	15
Old Injury	7	—	6	—	13
Hearing Def.	7	1	2	3	13
Poor Physique	1	4	5	—	10
Teeth Def.	8	—	—	—	8
Obesity	3	1	3	—	7
Speech	1	—	6	—	7
Arthritis	1	—	4	—	5
Varicocele	4	—	—	—	4
Epilepsy	—	—	—	3	3
Myalgia	2	—	—	—	2
Neurasthenia	—	—	—	—	2
Rheumatism	—	1	—	—	1
	393	59	312	15	779

Deferred for	Consulting Surgeon's report.	12
,, ,, ,,	Aurist's report	7
,, ,, ,,	Oculist's report	14
,, ,, ,,	Treatment or Observation	11
,, ,, ,,	Physician's report	4
		48

began to disappear. A standing order was issued that any man about whose category there was any doubt, or whose classification was not entered in his paybook, should be at once brought before a Board. By the

end of the war, the combing out of the garrison battalions yielded practically no Category " A " men.

One rather theatrical incident throws a sidelight on the man-power problem :

During the winter of 1917, Military Football Leagues were very active in Cairo and Alexandria, and as the soldiers in Cairo and Alexandria were supposed to be " B " Class men, the Inspector of Man Power, through the proper channel, requested that the Standing Medical Board should investigate the physical condition of all the football players in Cairo. The result was as follows :

Of the 400 footballers, about 270 were known to be " A " Class men employed in various administrative units, but 127 men were classed " B," and were accordingly reconsidered and reclassified. Of the 127 men some had recently been classified " B," and there was no suggestion that any change should be made. The 127 men were divided into Hospital Personnel, and Personnel of other Units. Of the 52 men employed in hospitals, it was decided to re-examine 16, of whom 14 were reclassified. Of the 75 belonging to other units, 44 were examined, of whom 35 were classified and 9 deferred. 31 were absent. It became a matter of extreme difficulty to trace the whole of these men and to get them before a Board.

The general result was as follows :

Of the 52 men of the Hospital Teams, 16 were re-examined, 4 were classed " A," and 2 " B.i Front Line."

Of the 75 remaining men, 44 were reclassified, 14 were classed " A," and 5 " B.i Front Line."

When the absent men were finally brought before a Board, the total result was a substantial gain for the " A " Class men. The position then taken up is indicated in the following statement :

"It need hardly be said that the fact of the 'B' Class man playing football, or taking other violent exercise, should be made an *a priori* reason for his Medical Officer at once submitting him to a Standing Medical Board." I do not wish to labour the importance of this incident in itself. Its importance lay in the indication it furnished of the necessity for tightening up the system, and it led to important developments in that direction.

In addition, during the examination of the garrison battalions previously referred to, two unusually powerfully made men presented themselves. I inquired of them what they had the matter with them, and they said they had nothing; when I asked them why they had been classed "B," they replied that they had been boarded in England and understood they had been made "B" Class men because they were professional footballers. They stated that they had no desire to remain "B" Class men and were quite prepared to do their work at the front. They were accordingly classified "A." It makes very little difference if a few "A" class men be kept at the base for special reasons, but it does make a profound difference if men once get it into their heads that other than military medical considerations enter into the decisions of the Boards, and the examination of the footballers in Cairo had an influence far beyond the intrinsic importance of the investigation itself.

The methodical examination of all "B" Class personnel on arrival in Egypt elicited facts of the most far-reaching importance. In general, about one-third of the "B" Class personnel who arrived in Egypt were immediately placed in the "A" category—that is, the Board regarded them as quite fit for front-line

service. They were sent to the front line, and I understand that the majority of them did the work quite well. This result was apparently owing to the different standards adopted by Boards in Great Britain and Boards in Egypt, and the difference in standards was in my candid conviction due to two causes :

1. That in Egypt the Boards were entirely in the hands of whole-time medical officers, and usually officers with temporary commissions.

2. In England some Boards were said to be conducted by civilian doctors, a number of whom had apparently not served abroad, certainly had not served in Egypt or Mesopotamia, and presumably did not fully understand the conditions, or what a soldier should be prepared to do.

A perusal of Chapter IX will indicate the divergence of views as regards visual standards alone. We learnt afterwards that the fact that so many men of the "B" category were classed "A" on arrival in Egypt was attributed in England to the salubrious nature of the climate in Egypt, which apparently produced this startling improvement within a week or two of their arrival in that placid country.

In closing this chapter it is necessary to remind the reader that the conclusions now presented in crystallized form were but dimly visible whilst the work was being conducted, and that it was only in the early part of 1918 that order was beginning to be evolved out of the loose system that had grown up. It is difficult now to realize that these recruits arrived in Egypt in many instances without specific information respecting the reasons why they had been classified "B"; and that as clinical information was rarely furnished by the British Medical Boards, the whole of the work had to be done over again. It was this circumstance that resulted in

the discovery that the standards differed so widely. At first the British classification was accepted without demur, but when scores and then hundreds of the men were returned by the Boards as fit who had been classed as unfit by British Boards, it became evident that there was a serious divergence of views. Presidents of Boards have often felt that the nation would have gained immensely had some of the presidents of the English Boards visited Egypt, and some of the presidents of the Egyptian Boards visited Great Britain, and that the disastrous shortage of men in the British Army at the commencement of 1918 might have been thus minimized.

CLASSIFICATION BOARD HELD AT TANTA

March 10, 1918

A newly arrived draft of 50 men to the . . . . . was examined. These men were classified "B" in England, but their A.B. 64 contained no statement as to their Class or disability.

Of the 50 men, 49 were present and one was absent in hospital. The following statement shows the changes in classification.

Disability for which classed "B" in England.	No. Classed.	Raised to "A."	Raised to "B.1 F.L."	Class Confirmed.	Deferred to see Specialists.
Vision	19	10	1	—	8
Debility . . .	8	5	1	2	—
Hearing . . .	2	2	—	—	—
Organic Heart Disease .	3	—	—	1	1
			(one lowered "B.iii")		
Age	2	—	—	2	—
Bronchitis . . .	2	—	1	1	—
Flat Feet . . .	1	—	1	—	—
G.S.W. (old) . . .	1	—	—	1	—
Loss of Finger (3rd left) .	1	1	—	—	—
Poor Physique . .	1	—	1	—	—
I.D. Knee Joint . .	1	—	1	—	—
Kyphosis . . .	1	—	1	—	—
Fractured Leg . .	1	1	—	—	—
Varicocele . . .	1	1	—	—	—
Pains in Back . .	1	—	—	—	1
Old Sprained Ankle .	1	1	—	—	—
Piles	1	—	1	—	—
Hernia . . .	1	—	1	—	—
Myalgia . . .	1	1	—	—	—
	49	22	9	7	10 & 1 lowered

In order that there may be no misapprehension of this point, the results are shown of a number of examinations of men who had just arrived in Egypt classed as Garrison Battalion men.

The first instance is given on page 70, from which it will be seen that of the 49 men examined, 22 were raised to Class "A," and 9 to Category "B.i Front Line," and it will be noticed that of the 31 men so raised, no less than 11 were raised on account of altered visual standards.

CLASSIFICATION BOARD HELD AT PORT TEWFIK
March 17, 1918

Disability.	No. Classed.	Raised to "A."	Raised to "B.i F.L."	Class Confirmed.	Deferred to see Specialist.
Vision	29	22	2	—	5
Debility	26	24	1	1	—
Hernia	16	1	2	12	1
G.S.W. (old)	13	6	3	4	—
Age	13	—	5	8	—
Feet	10	3	4	2	1
Hearing	8	7	—	—	1
Old Injury	7	4	1	—	2
D.A.H.	6	1	3	2	—
Poor Physique	6	—	2	4	—
Varix	5	2	2	1	—
Myalgia	3	3	—	—	—
Under size	3	—	2	1	—
Bronchitis	2	1	—	1	—
Neurasthenia	2	—	2	—	—
Rheumatism	1	1	—	—	—
Enlarged Thyroid (old history of)	1	1	—	—	—
Dyspepsia	1	—	1	—	—
Hysteria	1	—	1	—	—
Synovitis, Knee	1	—	—	1	—
Nephritis	1	—	—	1	—
Organic Disease of Heart	1	—	—	1	—
Piles	1	1	—	—	—
Hydrocele	1	—	—	1	—
Epilepsy	1	—	—	1	—
	159	77	31	41	10

Summary

Percentage raised to "A"	48·4
,, ,, ,, "B.i F.L."	19·5
Total	67·9

Another draft of 159 men, most of whom were new arrivals from England, were examined at Port Tewfik on March 17, 1918, with the result shown on page 71. Again it will be noticed that of the 77 men classed "A," 22 were raised on account of vision.

Again, during the month of March 1918, 69 men were examined who had arrived in Egypt and were stated to have been classified "B" in Great Britain. Of the 69 men examined, 49 were classed "A," 7 were classed "B.i Front Line"—that is, 56 out of a total of 69. The men classed "A" were said to be suffering from the following disabilities:

Hearing	1
Vision	7
Feet	1
Poor Physique	2
Gunshot Wound	2
Miscellaneous	5
No apparent disease	31
	49

The table is set out on page 73.

I have given these three instances because these drafts were examined at different times and places, and represented different arrivals. The results are tolerably uniform, justifying the general statement made in my report to the D.M.S. that of new arrivals in Egypt sent from Great Britain and allotted to garrison battalions, it may be said in general terms that about one-third are "A" class men, about one-third are "B.L. of C." and less than one-third are "B.i Front Line."

CLASSIFICATION BOARD, CITADEL
March 27, 1918

Disability.	No. Classed.	Raised to "A."	Raised to "B.i F.L."	Raised to "B.i L.C."	Confirmed "B.i L.C."
N.A.D.	31	31	The majority of these men stated that they had no idea why they were classed "B."		
Vision	10	7	2	—	1
Debility	5	—	—	3	1 (1 lowered to B.ii L.C.)
Feet	3	1	2	—	—
Poor Physique	3	2	—	1	—
Age	3	—	3	—	—
Hearing	2	1	—	1	—
G.S.W.	2	2	—	—	—
Hernia	2	—	—	2	—
Asthma	1	1	—	—	—
Loss of Finger	1	1	—	—	—
Neurasthenia	1	—	—	1	—
Varix	1	—	—	1	—
Rheumatism	1	1	—	—	—
Stature	1	1	—	—	—
D.A.H.	1	1	—	—	—
Organic Heart Disease	1	—	—	1	—
	69	49	7	10	2 (1 lowered)

Raised to "A" . . . . . 71 per cent.
„ „"B.i F.L." . . . . . 10 „ „

At the conclusion of the war a fresh batch of R.A.M.C. personnel were boarded, who had arrived in Egypt comparatively recently, and rather to the surprise of the Board we found that apparently there had been no material alteration of the British standards. These men had all been classed "B.i or "B ii." The total number of men reclassified was 83, and of these 21 were classed "A," and 16 "B.i Front Line." A number were deferred for further examination; and as many of them were in Category "B" for visual reasons, it is practically certain there will be several more "A" men amongst them.

CHAPTER VI

BOARDING SYSTEM (*continued*)

In the course of the work of the Standing Medical Boards, two other remarkable problems came to light, and came to light solely because of the existence of the Standing Medical Boards, since apparently there was no other mechanism in the R.A.M.C. available for their detection. When the hospital of Al Hayat, Helouan, was opened, it was intended to be a reception station for all disabled men who were unable to reach England on account of the submarine menace. At or about the time of its opening, however, the submarine campaign became somewhat mitigated, the Spanish Commissioners boarded all steamers, and this hospital, No. 71 General Hospital, was then made largely an Orthopædic and Convalescent Hospital as it was so well fitted with orthopædic appliances. As a result, every hospital in Egypt transferred its chronic cases to Helouan, and a most extraordinary collection of clinical material made its appearance. Cases that defied treatment, men who did not particularly want to get well quickly, men who were tired of the war, and a certain sprinkling of malingerers—in fact, all the tail of the army collected at Al Hayat. The nature of the problem soon became apparent; and the officer commanding the hospital, realizing the position, ordered that every patient who had been in the hospital for one month should be brought before the Standing Medical Board, and the

Board should then decide whether the man should be invalided, whether he should be classified, or whether further treatment should be continued. Furthermore, in every case inquiry was made as to how long such a man had been in hospital. The ordinary return sent to the D.M.S. from a hospital only indicated the time he had been in that hospital, and an attempt was now made to find out how long a number of these men had been in hospitals altogether. The table which follows indicates the rather remarkable position that had been reached:

71ST GENERAL HOSPITAL, HELOUAN

April 28, 1918

The following table shows the length of stay in hospital of 106 men who appeared before a Medical Board on the above date:

1	man had completed a period of			15	months
1	,,	,,	,,	12	,,
1	,,	,,	,,	8	,,
1	,,	,,	,,	7	,,
36	,,	,,	,,	6	,,
40	,,	,,	,,	5	,,
17	,,	,,	,,	4	,,
8	,,	,,	,,	3	,,
1	,,	,,	,,	2	,,

The average period in the above cases is 5·2 months.

Vigorous measures were taken by the Standing Medical Board, and before long the problem was solved.

When the hospital was broken up again, the evil disappeared from sight; for being distributed throughout all the hospitals in the Command, it was not sufficiently remarkable in any one hospital to attract much notice.

The second problem which arose was due to the prevalence of malaria, and particularly of the benign tertian and recurrent form. Patients suffering from the recurrent benign tertian form were ill usually one to three days every ten to fourteen days, and were

tolerably well in between. The usual routine was that when they reached their depot at Kantara they developed a shivering fit, were sent into the local hospital, which was always overcrowded, and were then transferred to either Cairo or Alexandria, where they arrived afebrile. They were watched carefully by a medical officer for eight to ten days, who, noticing nothing wrong, discharged them either back to Kantara or to a Convalescent Depot. Sooner or later they developed another shivering fit, and were again sent to another hospital, and the round began anew. They were known in the service as "The Round Trippers." Some of them had been travelling in this way from eight to fourteen or fifteen months, and had done no work during the whole of that period, since no one saw exactly what was occurring because of the fact that they usually obtained admission into a fresh hospital with each attack. The Standing Medical Board inquired into the matter, reported the facts, and, under instruction, classified these men "B.ii L. of C. Egypt, for Duty and Treatment." They were thus placed in a non-malarial region, they were kept under medical supervision, and when attacks came on they were placed in a small detention hospital for two or three days. This method put an end, not only to the problem, but in many instances to the disease, the combination of regular work with treatment producing most beneficial results. One of the Round Trippers gave evidence that he had been an inmate of every hospital in Egypt, but added that he was unable to say which one he preferred.

When the facts relating to the prevalence of "A" men in the Garrison Battalions were realized by the Administrative Medical Officers, steps were taken to adjust the difficulty, and the following certificate was

required every month from the medical officer in charge of the battalion :

"I certify that the remaining Class 'B' personnel (Officers and Other Ranks) who are in or attached to units under my medical charge, and who were due for re-examination during the past month, have been duly re-examined by a Medical Officer, and that I consider their classification should remain unchanged."

This meant that the whole battalion was medically inspected once a month, and that any man about whose category there was any doubt was submitted at once to the Standing Medical Board.

A number of other serious problems came before the Boards, and under instructions from administrative officers all anomalies were reported in detail, and by this means the administration gradually improved in efficiency; in other words, a seventh function had been imposed on the Standing Medical Board—that its members were to act as Medical Intelligence Officers and formally draw attention to any irregularities which came under their notice.

CHAPTER VII

STATISTICAL RESULTS OF THE WORK

It must be remembered that when the work of the Standing Medical Boards was begun in 1917, there was little printed or written evidence to guide them. No statistical evidence was available, and most medical officers had their own ideas about flat feet and the like. By way of preliminary, an analysis was made of 672 men who were classified by a Civilian Board—that is, a Board of temporary Military Medical Officers—in May 1917.

Of these 672 men, 150 were marked " B " for deformities of the feet, as shown in the sub-heading.

The remainder were classified as follows:

97 D.A.H.
53 V.D.H.
39 G.S.W.
51 Myalgia and Rheumatism.
29 Hernia.
30 Varicocele and Varix.
80 Debility.
37 Asthma, Bronchitis, and Emphysema.
10 Defective Vision.
15 Defective Hearing.
81 Miscellaneous.

Of the 150 men who were classed for deformities of the feet, no less than—

82 were for Flat feet.
24 ,, ,, Deformities of the feet.
23 ,, ,, Hammer toes, etc.
6 ,, ,, Injuries to ankles.
15 ,, ,, Miscellaneous.

A comparison of this table with subsequent tables will show the extent to which deformities of the feet disappeared, the extent to which myalgia disappeared, and the extent to which D.A.H. disappeared, whilst varicocele disappeared altogether.

With the foregoing facts recorded as a guide, the work began, and towards the end of October 1917 a classification had been effected of about 9,000 cases. A great many more had been examined, but as I had little clerical assistance it was impossible to keep count of all of them.

The result was as shown in the table on page 80.

The following report was drafted by me as the result of the work done up to October 31, 1917 :

1. *Area dealt with.*—The following report furnishes an account of the Classification of 8,918 Officers and men, who have been examined between the beginning of March 1917 and October 31, 1917. It does not by any means include all the cases boarded in that period, as there were no means of keeping records satisfactorily during part of the time, and the absence of clerical assistance made the work difficult. From March until the

SUMMARY OF RESULTS—INVALIDING AND CLASSIFICATION BOARD—HELD ON 8,918 CASES DURING 1917, MARCH TO OCTOBER

Disability.	Discharged from Hospitals.	Invalided to England.	Lines of Communication.	Cases at Base Depots.	Garrison Battalions.	Total.
Category "A"	191	—	1,961	592	700	3,442
Deferred Cases	121	—	249	146	203	719
Category "T.B."	159	—	58	466	29	712
Age (Debility)	149	—	88	114	499	750
G.S.W.	99	48	20	155	58	380
D.A.H.	58	4	83	57	63	265
Hernia	31	—	81	80	71	263
Vision (Defective)	72	—	96	18	38	224
Feet	26	—	80	30	75	211
Malaria	90	6	3	100	7	206
Debility	50	6	46	40	56	198
Bronchitis (including Asthma, Pleurisy, and results of Pneumonia	59	9	45	18	48	179
Organic Heart Disease (including Dilatation and Hypertrophy)	65	6	43	27	29	170
Miscellaneous	44	11	40	27	30	152
Deafness	68	1	17	10	21	117
Poor Physique	9	—	36	26	44	115
Injuries	24	4	29	17	35	109
Transfer	—	—	11	68	23	102
Arthritis (principally of knee, frequently due to football or displaced semilunar cartilages)	28	4	16	16	21	85
Varix	16	—	11	17	22	66
Neurasthenia	21	7	8	14	7	57
Unspecified	6	19	15	—	16	56
Mental	9	24	2	—	—	35
Myalgia	13	—	3	5	6	27
Bilharzia	22	1	1	2	—	26
Hysteria	15	1	2	2	5	25
Dysentery	9	7	2	3	3	24
Obesity	1	—	8	3	10	22
Epilepsy	14	1	1	—	4	20
Gastritis	7	12	—	—	1	20
Nephritis	7	9	2	1	0	19
Enteritis (includes simple Intestinal Infection)	11	4	1	0	2	18
Rheumatism	3	4	2	6	3	18
Speech	7	—	1	6	4	18
Tubercle	—	15	—	—	2	17
Appendicectomy	3	—	5	4	2	14
Goitre	2	3	5	3	1	14
Diphtheria	4	—	—	5	—	9
Piles	1	—	1	1	4	7
Nervous	2	2	—	1	—	5
Total	1,416	208	3,072	2,080	2,142	8,918

early part of June, the Boards were entirely confined to the hospitals in Cairo, but by direction after that date Boards were held systematically at Kantara, Port Said, Ismailia, Suez, El Arish, and Rafa, in addition to the Boards at Cairo. Furthermore, subsequent to the middle of June, Boards were held at various places in the Delta, namely Bilbeis, Zagazig, Tanta, and Benha. The total number of cases boarded during the period was between twelve and thirteen thousand, including, of course, some who were duplications.

2. *Local and Standing Boards.*—After the inspection of the Forces in Egypt by General Lawson, and the discussion respecting man power, orders were given to classify all men on the Line of Communication who had not already been classified, or about whom records were not obtainable. A very large number of men were consequently presented to Boards, and it became impossible for the Boards of which Lieutenant-Colonel Eason and I are Presidents to do the whole of the work. The D.M.S. then issued instructions that the A.D.M.S. or the D.D.M.S. of any district might form a Local Board, which had power to classify such men as "A" when they regarded them as fit, but they were to refer all doubtful cases to the Boards of which Lieutenant-Colonel Eason and I are Presidents, known as the *Standing Medical Boards*, for classification. As a very large number of men were classified "A" in this way, it will be seen that the 8,918 cases referred to in this report largely represented the residuum left by the investigation of other Boards.

3. *Methods adopted.*—The method adopted differed according as the men were: "Unclassified," "Lines of Communication," or "men from Garrison Battalions," "Base Depots" or "from Hospitals." Men on the Lines of Communication were examined two at a time, each by one member of the Board, and on completion of the examination were inspected by the President and examined or interrogated. Assuming that there was no need to refer such cases for a specialist's opinion respecting Vision, Hearing, or other condition, it was possible to examine satisfactorily in this way about thirty cases an hour, and, by working ten hours a day, to dispose of 300 in the course of the day. The remaining cases were presented with a clinical report, often by the Medical Officer in charge himself. They were dealt with one at a time, and with the machinery in excellent order could not be dealt with much more rapidly than twenty to twenty-five in the hour.

Two hundred represented a good day's work. The procedure adopted after experience by the D.M.S./E.E.F., Surgeon-General Maher, was that suggested to him by the President of the Classification Board in Alexandria, Lieutenant-Colonel Eason, C.M.G., and myself. The memorandum embodying directions he gave is attached herewith, together with the form ultimately adopted. The great merit of the form used is the use of carbon papers. The roll can be prepared in quadruplicate, the decision of the Board filled in by the Chairman, so that by the end of the day, when the Board rises, the clerical work is practically finished.

4. *Character of the Work.*—It is necessary to say something of the character of the boarding conducted under the several headings :

(*a*) Cases boarded at the Hospitals in Cairo are usually presented with a wealth of clinical information, which makes the decision, in the majority of cases, a comparatively simple matter, and especially in the case of men invalided to England. The clinical work would, in my opinon, be difficult to improve.

(*b*) The work done in the Lines of Communication units, dealing as it does largely with healthy men, is comparatively simple, but even here constant reference must be made to an Oculist and Aurist and occasionally to a Surgeon and Heart Specialist ; in fact, so constant are the references to Vision and Hearing, that latterly I have arranged that an Oculist and Aurist shall be in attendance during all Boards, apart from the Hospital Boards.

(*c*) At the Base Depots the problem is entirely different. The majority of the cases presented are cases marked T.B. and Discharged from Hospitals, or men who have not been boarded before. They constitute the most unsatisfactory part of the work, and are referred to at some length later in this report.

(*d*) The combing out of the Garrison Battalions has now been thoroughly done. The clinical work has usually been prepared with some care by the Medical Officers in charge, and the procedure has been smooth and certain.

5. *Results.*—The results of the examination are set out in the table (see page 80) and show at a glance the principal causes of disability.

Under the headings DEFER and TRANSFER are cases which are often duplications. They represent cases which were referred

for further examination or other causes. Under the heading T.B., too, the cases are practically deferred decisions, but all the DEFERS, TRANSFERS, and T.B.s do not reappear in the subsequent classifications, as in some instances they were classified elsewhere, viz. at Alexandria or by Local Boards.

(*a*) Reviewing the results under the several headings: The 1,416 cases under the heading DISCHARGED FROM HOSPITALS must have subtracted from them the "A" 191, DEFER 121, and T.B. 159, leaving 945; these represent the residual cases which entered Hospitals in Cairo and were found unfit for "A" work afterwards.

(*b*) The small number of men INVALIDED TO ENGLAND will attract notice. Nothing is more striking than the fact that the number of men who will not be fit for any sort of service after five months is very small indeed, and that the necessity for Hospital Ships is not very great.

(*c*) *Lines of Communication.*—The bulk of these cases were healthy men, and had probably been examined before entrance to the Army. They include A.S.C., A.O.D., R.E., R.A.M.C., and other special units.

(*d*) The cases at the BASE DEPOTS include T.B. cases discharged from the Hospitals and transferred to Base Depots, and also drafts sent to the Base Depots on their way to the front, and there arrested by their Medical Officers and brought before a Board. About the T.B. cases more will be said in a special paragraph.

(*e*) *Garrison Battalions.*—While it is true the periodical combing of the Garrison Battalions will yield a certain number of fit men, the number will not be nearly so great in the future. A large proportion of the "A" men in the Garrison Battalions were men drawn from the Special Reserve, or men who had never been examined at all, or men who had been for a long term in a Garrison Battalion and had completely recovered from any disability they had suffered from. In spite of the large proportion of men marked "A" to which must be added many of the cases marked DEFER or TRANSFER, it must be remembered that these only represent a moderate proportion of "A" men obtained from the Garrison Battalions. The Local Boards classed many more of the men "A." It is doubtful whether in some cases Garrison Battalions did not contain as many "A" as "B" men. Cases now being classed "B.i" for wounds, D.A.H., and

the like, will in some cases become "A" men, and the future combing out will yield the residuum of such cases, but the numbers, as before indicated, are not likely to be very great.

6. *Clinical Reasons for Classifying Men "B."*—It will be seen that, apart from GUNSHOT WOUNDS, the principal cause of the "B" Classification was D.A.H., which comes second on the list of Disabilities, and which in many cases probably represents a general physical failure. The question has arisen repeatedly whether some of these cases may have been artificially induced, but there never has been anything to suggest such causation, and circumstances have prevented the necessary investigation being made, though such an investigation had been planned.

It will be noticed that Hernia comes third on the list. By direction of the D.M.S./E.E.F., all the Hernia cases were classed "B.i," and fitted with trusses where operation was declined. The view taken was that if discrimination was exercised, it would result in a procession of men up and down the line, and would not be satisfactory. It was thought better to class them all "B.i," fit them with trusses, and keep them as a potential reserve, and if necessary send the whole of them to the front line as a reinforcement.

The large number of Defective Vision cases, which come fourth in the list, is very instructive, in view of the moderate standard adopted in Egypt on the advice of the Consulting Oculist E.E.F. Were the standard originally fixed officially adhered to, it is no exaggeration to say that hundreds or even thousands of useful men, fit for the front lines, would immediately be relegated to the "B" class.

The Army Council Orders relating to Flat Feet have had their effect, and Deformities of the Feet have now passed from first to fifth place, and are likely to be still lower.

Deafness, which comes eleventh on the list, occupies a subordinate place. The diffusion of knowledge relating to the comparative innocuousness of Otitis Media, and the attention given to this condition by the R.A.M.C. Officers, has rendered it a formidable item no longer.

It will be noticed that both Neurasthenia (seventeenth) and Hysteria (twenty-second) are low down on the list, and that Shell Shock does not appear at all. The number of genuine cases of Shell Shock which have come under notice are negligible.

7. Reviewing the causes of Disability, I find it difficult to

suggest any method by which the numbers can be still further reduced, except (1) by an investigation into the possibility of artificial inducement of D.A.H., (2) the use of all the Hernia cases, (3) greater care of the feet and the use of the Regimental Bootmaker, and (4) some limitation on the playing of football.

8. *Standards.*—If the war continues, and more men are wanted at the Front, it will not be easy to get them by further lowering of standards, apart from the suggestions already made, but the "B.i" men in the Garrison Battalions, if given some help with transport, would form a valuable reinforcement from the physical point of view. They are composed in most cases of elderly men, of considerable experience and often of considerable ability.

9. "*T.B.*"[1]—Surveying the work of the Boards, certain changes seem desirable. Undoubtedly the greatest leakage, abuse, and wastage occurs in the class "T.B." The "T.B." is so made by the Medical Officer of the Hospital with the concurrence of the Medical Officer of the unit. He is not to be "T.B." unless it is tolerably certain he will be "A" within five months. Having been classed "T.B." he is sent to a Base Depot, and does miscellaneous fatigues and occasional drills. The experience of the Board has been that when his period of "T.B." is up, he shows too often a decided disinclination to shift his position. He does not feel well, he is not at all fit, and the tendency was to extend the period. The Board speedily found in many cases, particularly D.A.H. and Neurasthenia, that at the end of one or two extensions of period he was certainly no better than he was at the beginning. The Board accordingly made a clean sweep and classed them all "A" or "B." The life of the man in the camp as a "T.B." case has been more or less demoralizing under existing conditions. The miscellaneous character of the work, the alternations of activity, and the lack of physical drill, have not conduced to his betterment. I beg to recommend that in future men discharged from hospitals should not be classed "T.B." except by a Hospital Board, and that they should never be classed "T.B." unless it is almost certain that they will become "A" within a specific and reasonable time, say two months. If there is lack of certainty, they are better placed in a Garrison Battalion, where the regular work, discipline, and mode of life under one medical

[1] "T.B." meant Temporary Base, but is now replaced by Category D.

officer are more conducive to recovery. In my opinion the field of the "T.B." case wants more supervision and certainly requires limitation. It might indeed be replaced in part by a Command Depot.

10. To whatever extent the E.E.F. may grow, it does seem desirable that Boards which have authority to classify men "B" should be as few as possible, and that the personality of the President should vary as little as possible. There is no objection to giving authority to divers Boards to classify men "A," because if a mistake is made it so soon rectifies itself. Once, however, a man is classed "B," considerable difficulty may be experienced in reclassifying him "A." It is for this reason that the three Presidents of Boards have arranged to meet periodically to discuss problems which arise, to keep one another informed of any difficulties, and to mutually respect the classifications of the Standing Medical Boards presided over by the three medical officers respectively. The beneficial results of this policy have already become abundantly apparent, and the extension of the policy by the creation of a Statistical Department relating to Invaliding and Classification Boards might be of great assistance to the Army in Egypt.

Towards the end of 1917 the work was well in hand, and the D.M.S. divided the work between three districts, namely, Alexandria, Delta District (including the canal but excluding Kantara), and Palestine L. of C.

The next set of figures relate only to the Delta District and refer to the months of October (part), November, and December, the number of cases being 4,587. The reasons for the increase of number are that some clerical help was now available, and the returns were being kept more accurately. Noticeable in this table is the appearance of cases of malaria in vast numbers (due to the fact that the D.M.S. ordered that all malaria cases should be classified "B" for a term), the great reduction in the number of D.A.H. cases, and the very low place now occupied by Feet.

SUMMARY OF RESULTS ... MEDICAL BOARDS HELD ON 4,587 CASES

Period: Latter Half of October and Months of November and December 1917

Disability.	Boards Conducted at Hospitals.				Conducted on Garrison Battalions.			Conducted on L. of C. Units.			Grand Total.
	"B."	"D."	"C."	Total.	"B."	"D."	Total.	"B."	"D."	Total.	
Malaria	2,066	21	10	2,097	2	—	2	4	—	4	2,103
"A"	—	—	—	343	—	—	211	—	—	304	858
G.S.W.	220	55	145	420	5	—	5	9	1	10	435
Debility	67	27	12	106	25	2	27	17	4	21	154
D.A.H.	54	11	5	70	14	5	19	17	1	18	107
Age (Debility)	38	—	—	38	13	—	13	46	—	46	97
Bronchitis (including Pleurisy, Asthma, and results of Pneumonia)	60	7	1	68	15	—	15	13	—	13	96
Vision (Defective) (including Loss of Eye, etc.)	47	—	1	48	12	—	12	13	—	13	73
Organic Heart Disease (including Dilatation and Hypertrophy)	48	1	5	54	7	—	7	10	—	10	71
Dysentery (including Enteritis, Enteric, Jaundice, Diarrhœa, Appendicitis, etc.	40	12	13	65	1	—	1	4	1	5	71
Miscellaneous	41	1	6	48	3	8	11	8	—	8	67
Myalgia (including Rheumatism, etc.)	40	7	3	50	3	—	3	2	—	2	55
Injury	27	11	2	40	4	1	5	6	—	6	51
Hernia	19	6	—	25	3	—	3	14	—	14	42
Arthritis (principally of knee, frequently due to football or displacement of semilunar cartilages)	17	7	5	29	2	—	2	5	1	6	37
Neurasthenia	22	7	1	30	—	—	—	5	1	6	36
Feet (including Hallux Valgus, Deformed Feet, Flat Feet, Pes Cavus, etc.	13	1	—	14	3	1	4	12	1	13	31
Deafness	16	1	—	17	8	—	8	6	—	6	31
Nephritis	15	1	6	22	—	—	—	6	—	6	28
Poor Physique	5	—	—	5	10	—	10	7	—	7	22
Varix	10	4	—	14	1	—	1	6	—	6	21
Diphtheria	7	12	2	21	—	—	—	—	—	—	21
Insanity (including Feeblemindedness, Melancholia, and Psychasthenia)	—	—	15	15	—	—	—	2	—	2	17
Hysteria	10	3	2	15	—	—	—	2	—	2	17
Nervous (including Neuritis, etc.)	6	6	3	15	—	—	—	—	—	—	15
Epilepsy	13	—	—	13	—	—	—	—	1	1	14
Tubercle	1	—	8	9	—	—	—	—	—	—	9
Bilharzia	4	—	—	4	—	—	—	—	—	—	4
Speech	1	—	—	1	1	—	1	1	—	1	3
Goitre	1	—	—	1	—	—	—	—	—	—	1
Total	2,908	201	245	3,697	132	17	360	215	11	530	4,587

During 1918 some clerical assistance was provided, and consequently greater accuracy was obtained, and the following table represents a copy of the report furnished for the half-year ending June 1918, 13,393 cases being dealt with. The results noteworthy in this table are the facts that D.A.H. becomes practically a negligible quantity; Defective Vision still occupies a high place; Myalgia and Rheumatism are low down on the list; Defective Feet only account for 237 cases out of the 7,134 classified "B." It will be noted, too, that D.A.H. cases treated in April, May, and June at the Command Depot, 360 in number, furnished no less than 232 "A" Class men; in other words, D.A.H. had to an extent disappeared. Experience has shown that what has been called "D.A.H." is usually rapid heart action, due to exhaustion from some temporary cause, and that with suitable treatment and graduated training the disability disappears.

The extent to which heart diseases gave trouble may be gathered from the following figures: from February to October 1917, the Standing Medical Board classified 261 men for D.A.H. and 170 men for V.D.H. During the period from October to December 31, 1917, in the Delta District, the Board classified 107 men for D.A.H. and 61 for V.D.H. During January and February 1918, in the same district, the figures were 97 D.A.H., and 64 V.D.H. Comparison of these figures with those obtained subsequently when the heart clinic was fully developed are rather instructive. It is impossible to classify satisfactorily men with heart diseases without ascertaining by proper methods what the heart can stand.

STANDING MEDICAL BOARD, DELTA DISTRICT

Half-year ending June 30, 1918

(*a*) NUMBER OF CASES DEALT WITH

Class.	Hospitals, Convalescent Depots, Command Depot.	Garrison Battalions.	L. of C. Personnel.	Total.
A	792	798	568	2,158
D	343	144	57	744
"B.i. Front Line"	242	364	295	901
"B.i. L. of C." / "B.ii." ,,	2,026	1,294	685	4,005
"B.iii." ,,	499	295	110	904
Invalided	1,324	—	—	1,324
Deferred	642	548	259	1,449
Total	6,068	3,443	1,974	11,485
Prisoners of War				1,817
Extraneous				91
Total				13,393

(*b*) CASES CLASSED OTHER THAN "A"—SUMMARIZED ACCORDING TO DISABILITIES

Disability.	Hospitals, etc.	Garrison Battalions.	L. of C.	Total.
G.S.W.	1,157	155	47	1,359
Age	142	495	158	795
Debility	333	172	136	641
Miscellaneous	331	95	54	480
Malaria	367	7	16	390
Bronchitis (including Asthma and Pleurisy)	174	107	54	335
Organic Heart Disease	141	114	76	331
Vision (Defective)	111	98	102	311
D.A.H.	108	93	54	255
Hernia	69	113	63	245
Feet (Defective)	51	96	90	237
Injury	107	57	44	208
Arthritis	102	36	24	162
Hearing (Defective)	55	70	24	149
Poor Physique	13	85	41	139
Neurasthenia	85	15	14	114
Rheumatism	59	25	21	105
Varix	34	48	22	104
Diphtheria	89	2	4	95
Nephritis	69	3	6	78
Mental Disease or Deficiency	68	5	4	77

(*b*) CASES CLASSED OTHER THAN "A"—SUMMARIZED ACCORDING TO DISABILITIES (*continued*)

Disability.	Hospitals, etc.	Garrison Battalions.	L. of C.	Total.
Enteritis (including simple Intestinal Infection)	63	5	3	71
Tubercle of Lung	68	—	—	68
Epilepsy	38	16	4	58
Myalgia	39	9	2	50
Dysentery	38	—	—	38
Neuritis	33	2	1	36
Phthisis	30	—	—	30
Hysteria	18	7	3	28
I.C.T.	22	1	3	26
Appendicectomy	19	2	5	26
Speech (Defective)	5	10	6	21
Bilharzia	9	—	4	13
Arterial Sclerosis	9	2	—	11
Albuminuria	6	—	2	8
Obesity	2	5	1	8
Int. Derangement Knee	4	3	1	8
Gastritis	6	—	1	7
Colitis	6	—	—	6
Sciatica	6	—	—	6
Rheumatic Fever	5	—	—	5
Total	4,091	1,953	1,090	7,134

(*c*) ANALYSIS OF 892 CASES INVALIDED DURING APRIL, MAY, AND JUNE

Disability.	No. of Cases.	Disability.	No. of Cases.
G.S.W.	313	Arthritis	10
Miscellaneous	101	Neuritis	10
Mental	54	Epilepsy	9
Tubercle of Lung	50	Ent. Infection	9
Debility	37	Diphtheria	7
Organic Heart Disease	36	Arterial Sclerosis	6
Bronchitis (including Asthma and Pleurisy)	31	Colitis	5
Age (and debility, etc.)	28	Rheumatic Fever	3
Nephritis	28	Hysteria	3
Malaria	25	Gastritis	3
Phthisis	25	Bilharzia	3
D.A.H.	21	Myalgia	2
Dysentery	20	Inflammation of Stomach	2
Vision	16	Rheumatism	2
Neurasthenia	15	Appendicitis	2
Injury	13	Total	892

D.A.H. RETURN

(*d*) CASES RETURNED TO DUTY AFTER TRAINING AT COMMAND DEPOT, ABBASSIA, DURING MONTHS OF APRIL, MAY, AND JUNE, 1918

As Class "A"	242
,, ,, "B.i. Front Line"	3
,, ,, "B.i. L. of C."	60
,, ,, "B.ii ,,	35
,, ,, "B.iii ,,	20
Total	360

(*e*) TABLE SHOWING THE TOTAL NUMBER OF CASES DEALT WITH EACH MONTH

January	1,463
February	1,460
March	2,224
April	2,673
May	2,622
June	2,951
Total for half-year	13,393

It was suggested early in 1918 that "A" Class men should be classified according to occupations for which they were physically fit. For example, some men might be "A—mounted work"; men, for example, with flat feet and similar men might be classed "A—motor work." Similarly a man might be classed "A—motor work" who had good vision in one eye and was not totally blind in the other, *i.e.* who could not be a marksman. Finally, however, it was decided that there could be no classification of "A" Class men, but that men might be marked "B.i. Front Line," and sub-classified as might be thought fit, which came to very much the same thing.

The following table indicates the work that was done during the four months ending October 31, 1918 :

STANDING MEDICAL BOARD, DELTA DISTRICT

(*a*) CASES DEALT WITH DURING THE MONTHS OF JULY, AUGUST, SEPTEMBER, AND OCTOBER 1918

Officers.			Other Ranks.		
Class.	No.	Hospitals, Convalescent Depots, Command Depot.	Garrison Battalions.	L. of C. Personnel.	Totals.
"A" . . .	40	375	176	245	836
"D" . . .	39	338	7	17	401
" B.i. Front Line .	3	148	158	193	502
" B.i. L. of C." . .	42	460	267	177	946
" B.ii" „ . . .	41	659	179	126	1,005
" B.iii " „ . . .	38	304	55	35	432
Invalided . . .	119	1,215	—	—	1,334
Deferred . . .	8	263	110	96	477
Total . . .	330	3,762	952	889	5,933
Repatriation Boards—Prisoners of War . . .					1,353
Repatriation Boards—Palestine Jews . . .					35
A.45—a and b					46
Commissions					45
Extraneous					49
Total					7,461

(*b*) ANALYSIS OF CASES RECOMMENDED FOR INVALIDING

Disability.	No. of Cases.	Disability.	No. of Cases.
G.S.W.	249	Rheumatic Fever . .	10
Miscellaneous . . .	179	Colitis	9
Malaria	152	Arthritis	8
Dysentery	151	Epilepsy	7
Tubercle of Lung . .	89	Diarrhœa	6
Mental	78	D.A.H.	6
Debility	75	Inflammation of the Stomach	6
Bronchitis (including Pneumonia, etc.) . . .	68	Inflammation of Joints .	5
Injury	47	Arterial Sclerosis . .	4
Phthisis	46	Hysteria	4
Neurasthenia . . .	32	Jaundice	3
Organic Heart Disease .	31	I.C.T.	2
Nephritis	17	Myalgia	2
Enteritis	16	Relapsing Fever . . .	2
Neuritis	16	Diphtheria	2
Vision, Defects of . .	12	Total	1,334

D.A.H. RETURN

(*a*) CASES RETURNED TO DUTY AFTER TRAINING AT THE COMMAND DEPOT, ABBASSIA

As Class "A"	182
,, ,, "B.i. Front Line"	4
,, ,, "B.i. L. of C."	38
,, ,, "B.ii. ,,	32
,, ,, "B.iii. ,,	5
	261

(*b*) CASES CLASSED "B"—SUMMARIZED ACCORDING TO DISABILITIES

Disability.	Officers. No. Classed.	Officers. Hospitals, etc.	Other Ranks. Garrison Battalions.	Other Ranks. L. of C. Personnel.	Total.
Malaria	22	415	33	9	479
Debility	16	215	106	97	434
Age (and debility)	11	59	218	70	358
G.S.W.	15	219	36	21	291
Miscellaneous	15	110	30	28	183
Feet (Defective)	—	41	27	58	126
Vision (Defective)	1	37	30	48	116
Hernia	1	49	30	27	107
Bronchitis (with Pleurisy)	4	57	29	15	105
Organic Heart Disease	5	47	15	36	103
Injury	6	62	15	15	98
D.A.H.	2	21	18	27	68
Poor Physique	1	18	25	23	67
Neurasthenia	3	33	7	8	51
Hearing (Defective)	3	22	7	16	48
Arthritis	1	27	9	6	43
I.D.K.J.	3	19	1	4	27
Varix	1	11	7	7	26
Epilepsy	—	21	—	3	24
Myalgia	1	13	4	4	22
Nephritis	—	14	—	2	16
Appendicectomy	2	9	1	3	15
Diphtheria	1	12	—	—	13
I.C.T.	—	12	—	—	12
Enteric Infection	4	5	1	—	10
Dysentery	1	9	—	—	10
Rheumatism	2	—	6	1	9
Speech (Defective)	—	2	1	3	6
Arterial Sclerosis	3	2	1	—	6
Hysteria	—	2	2	—	4
Psoriasis	—	3	—	—	3
Neuritis	—	3	—	—	3
Sciatica	—	2	—	—	2
Totals	124	1,571	659	531	2,885

Number of men whose category was lowered from "A" to "B" 838
,, ,, ,, ,, ,, ,, raised from "B" to "A" . 301

Conspicuous features, however, are the steady increase in the malaria cases as they were classified for Base work, and the practical disappearance of the D.A.H. cases.

One of the most remarkable circumstances which came under my notice resulted from the application of the systematic methods of the Standing Board to the Base Camp at Kantara. The Base Camp was filled with men discharged from hospitals, and graded "T.B." (Temporary Base). These men were supposed to be examined once a week by a medical officer, and were ultimately classified "A" or "B." The tendency of the Board was to extend the period if they were not progressing favourably; and when the Standing Medical Board took over, the members found the camp filled with many hundreds of more or less demoralized men, who were sometimes doing a fatigue and sometimes a parade. Feeling their way, the members of the Board extended their periods once or twice in a certain number of cases and found that at the end of the extension many men were no better, and in some cases were even worse than before; they were accordingly either classified "A," or transferred to one of the "B" categories and put to garrison work, and in a few weeks the camp was emptied. Only those who are used to Army Medical work realize the way in which men can be demoralized by too much, and injudicious, kindness. The discharge of these men to work put an end to the trouble in the camp, and in most cases effected amelioration of the men's physical condition.

NOMINAL ROLL of Officers and other ranks who APPEARED BEFORE A MEDICAL BOARD at.....on.....1918
and who were RECOMMENDED FOR CLASSIFICATION AS BELOW.

Note: (1) All columns starred must be left blank for the use of the Board. (2) All other columns should be completed in detail by Unit concerned. (3) Clinical information should be forwarded on separate slip of paper.

Regtl. No.	Rank.	Name.	Regiment.	Civil Occupation.	Age.	Disability.*	Pres. Class.	New Class* Front Line or L. of C.	Suggested* Occupation.	Clinical Notes.*

President.....Member.....Member.....

A.P. & S.D., Alex./$\frac{4199}{50025A}$ 7:18/20M.—R.B.

THE CLASSIFICATION FORM ADOPTED.

CHAPTER VIII

REPATRIATION BOARDS

The Repatriation Boards were of several classes. In those conducted on Germans, the procedure was strictly defined by the Anglo-German agreement, and the disabilities for which repatriation or internment in Switzerland might be requisite are laid down with meticulous precision. In the case of the Bulgarians, and still more so in the case of Ottoman Turks, greater latitude was given. The practice adopted was to classify these men in the same manner as English soldiers. As a matter of fact, 1,300 invalid Turks were wanted for repatriation, but out of some thousands of Ottoman Turks examined only a percentage were in such a poor condition that repatriation could be recommended, and it might have even become necessary to send partially fit men back to Turkey, in order to secure the release of our own men who were imprisoned. In order that the military authorities might know exactly what they were doing, and whom they were returning, it was laid down that a disability of 40 to 50 per cent., which was likely to be permanent, warranted classification "B iii. L. of C." and that 50 per cent. disability or more warranted discharge from the service; accordingly all "B iii. L. of C." and all "C" cases were recommended for repatriation.

The feature of the work amongst the Turks was

the extraordinary prevalence of pellagra, a condition which was so serious that the Commander-in-Chief, E.E.F., ordered special inquiry to be made. The report of the commission will doubtless make its appearance in due course, but one outstanding fact in connection with pellagra may be worth mention. There was, during the war, an Armenian Refugee Camp at Port Said. At this camp pellagra made its appearance. The lady doctor in charge of the camp insisted that the Calories in the Dietary should be increased; this was done, and in the course of six months the pellagra disappeared and did not recur. The instance is probably classic, for never anywhere else has it been possible to test the effect of an alteration of diet on people living in the same position, in the same climate, with the same occupation, and in people of the same race. The only altered condition, as far as we know, was in the diet.

Unfortunately with pellagra came an epidemic of destructive ophthalmia, which caused a large amount of blindness. Once the cornea of a pellagraic Turk became ulcerated, the eye was not long in being lost. The ophthalmia was not gonorrhœal, but was of the Koch-Weeks type. The most strenuous efforts were made to grapple with the difficulty by the Consulting Oculist and his staff, and it was ultimately got under. Interest is likely to centre in the fact that a similar outbreak occurred in Napoleon's Army at the beginning of the nineteenth century, and yet in the four years in Egypt only one eye of a British soldier has been lost from ophthalmia, a circumstance attributed by some army surgeons to the abolition of the roller towel.

The classification of the Turks furnished a good deal of clinical information of interest. Heart cases, whether

organic or functional, appeared to be rare, whilst tubercle of the lung, with or without pellagra, appeared to be very common indeed. There is no doubt that one of the reasons for the extensive spread of pellagra in the Turkish Army was the fact that the Turkish Medical Officers themselves did not recognize the disease; a circumstance not very remarkable, for until the characteristic signs were pointed out, few medical officers recognized pellagra in its earliest stages. There is no doubt its existence amongst the Turkish prisoners has furnished an invaluable opportunity for the investigation of this scourge, and it has thrown a flood of light on the tradition of Egyptian ophthalmia, which had become quite discredited from recent favourable experiences in the British Army. In thirty years of ophthalmic practice, I have never seen anything approaching the destruction wrought by this disease in spite of the most determined efforts made to stop it. Like trachoma in Egypt, it is probably a direct product of the habits of the people.

Of the Turkish prisoners of war about 3,000 were presented for Boarding, and of these 1,783 were adjudged "B.iii. L. of C." or Fit for Discharge, and were recommended for repatriation. It is noteworthy that of these Ottoman Turks recommended for repatriation, no less than 117 were recommended on account of total blindness due to ophthalmia, apart from a large number of others whose vision in one eye had been completely lost, or whose vision in both eyes had been extensively damaged.

CHAPTER IX

STANDARDS OF VISION

The variations and mode of thought respecting standards of vision have been so numerous and the practical consequences during the war have been so serious that I propose to devote some little attention to them, and to indicate how grave may be the consequences of adopting artificial standards without sufficient scientific evidence. I set aside for the present consideration of the vision of officers and limit myself entirely to a discussion of the vision of the men.

Before the war recruits were supposed to possess vision of 6/24 in each eye without glasses, or 6/6 in one eye and 6/36 in the other. The foregoing was the standard test of vision for all arms of the service including militia, yeomanry, and volunteers, with the exception of a corps of Army schoolmasters for which a candidate was accepted if the examiner considered that his vision was good.

Who devised these standards I do not know, and I find it difficult in the light of modern knowledge to understand the advocacy of such a standard.

A vision of 6/24 in each eye without glasses is for ordinary purposes very good vision, assuming there is no ocular disease, but the adoption of such a standard implies the rejection of all myopes of low degree and of a number of men suffering from other errors of refraction;

in fact, such a standard if adopted would have excluded thousands of men from the front line in the E.E.F. who did their work very well.

It was quite evident that this pre-war standard was impossible, and the Army Council issued a second order:

> If a man's vision is 6/24 in one eye without glasses, and his right eye can be brought up to 6/12 with glasses, he will be considered fit for Category "A" (Army Council Instruction No. 211, dated 4/2/1917).

This standard excluded all left-eyed men and all low myopes and soldiers possessing some other errors of refraction, and consequently when the nation's manpower began to run out the D.M.S./E.E.F., after consultation with the Consulting Oculist, E.E.F., fixed the standard for men already in the service as 6/24 in the right eye with or without glasses, providing he was not blind in the left eye; blindness was defined as inability to count fingers at three feet. The minimum standard was fixed by the Army Council at 6/60 in one eye without glasses, that of the other eye being less or nil.

The Egyptian standard worked very smoothly, and by its adoption hundreds of men were sent to the front line and did very well indeed. An attempt was made to amend this regulation by making it apply to the left eye, *i.e.* to read "that vision of 6/24 in either eye with or without glasses, provided the other eye was not blind," but the authorities pointed out that it was impracticable to give instruction in musketry in Egypt to left-eyed men, and accordingly such men were passed into the front line "R.A.M.C." or "A.S.C.," etc., if otherwise fit.

When many hundreds of men had been so classified, the D.M.S. cancelled the order and reverted to the standard previously alluded to, on the grounds that he could not modify an Army Council instruction. At this juncture, however, the Army Council issued another instruction, which was as follows :

If a recruit can read, without glasses, not less than 6/12 with each eye, he may be accepted for Category "A" without examination by an ophthalmic specialist.

If the vision is below this standard, the recruit shall be sent for examination to an ophthalmic specialist.

Instructions to Ophthalmic Specialists. Category "A."—A recruit will be considered fit for Category "A" if his vision without the aid of glasses is not less than 6/60 with one eye (R. or L.) and not less than 2/60 with the other, provided that, with the aid of glasses if necessary, his vision is not less than 6/12 with one eye and that both eyes have good field of vision as tested by hand movements.

Category "B."—"B.i." A recruit whose vision is not equal to the standard laid down for Category "A" will be considered fit for Category "B.i." if his vision without the aid of glasses is not less than 3/60 with the better or only eye, provided that with the aid of glasses his vision is not less than 6/18 with one eye.

B.ii. A recruit whose vision is not equal to the standard laid down for Category "B.i" will be considered fit for Category "B.ii" if his best obtainable vision with the better or only eye (with or without glasses) is not less than 6/60.

Men in the Labour Corps whose best obtainable vision, aided if necessary with glasses, is less than 6/24 with the better or only eye will be considered unfit for dangerous employment such as dock labour, railway shunting, etc.

B.iii. The standard of vision for clerks will be the same as for "B.i," while that for other occupations referred to in para. 6 "B.iii" of A.C.I. 1606 of 1917, viz. storemen, batmen, cooks, orderlies, sanitary orderlies, or skilled tradesmen, will be the same as for "B.ii."

Note.—(1) A man may be passed into Category "B.i, B.ii, or B.iii if one of his eyes has been lost or is completely blind, provided that the remaining or better eye is up to the required

standard and has a good field of vision as tested by hand movements.

(2) No man will be accepted for any form of military service with a lower standard of vision than that laid down for "B.ii."

SERVING SOLDIERS

In retesting the vision of serving soldiers the standard will be the same as for recruits, but men who have been found capable of carrying out their duties efficiently need not necessarily be placed in a lower category on account of their eyesight not being equal to the standard laid down for the category in which they are serving.

This standard was undoubtedly better than that adopted according to previous Army Council instructions from the point of view of obtaining "A" Class men, but it was far inferior to that laid down by the Consulting Oculist, E.E.F., which had worked exceedingly well, and its very artificiality raised doubts respecting its practicability.

It has been the fortune of the writer to act as Consulting Oculist to a number of Steamship Companies and to the Pilot Service in Melbourne, and to investigate the condition of vision of the pilot who was responsible for the loss of the P. & O. steamer *Australia* in 1904. In the course of these investigations he has taken a great deal of trouble to find precisely what men with 6/24 vision can or cannot see. He rendered himself artificially myopic with glasses both when at sea and on land, and found that with a 6/24 vision, all ordinary operations can be carried out without difficulty, navigation can be undertaken in fine weather, and objects can be seen, distances judged, though details are not so clear as they usually are. Where the man of 6/24 vision or even 6/12 vision comes to grief as an engine-driver or as a mariner is that with these defects

of vision there is a marked degree of colour blindness, as has been clearly shown by Sir William Abney; but as the majority of soldiers do not have to discriminate between coloured lights at night, the futility of setting a high standard is apparent. The facts relating to these investigations were placed before the British Association for the Advancement of Science at its meeting in Melbourne in 1914. It is, however, necessary to labour the question, since no less an authority than the late Director-General of Army Medical Services, Sir Alfred Keogh, in a War Office memo. dated August 14, 1916, says :

With reference to the scheme for the issue of spectacles to troops, I am directed to inform you that in many cases it would appear that soldiers are ordered glasses quite unnecessarily. I am accordingly to submit the following remarks for the guidance of all concerned, and to point out that the conclusions arrived at are the result of the experiences gained by ophthalmic surgeons at the front in France, after the examination of many thousands of men sent down from the firing-line complaining of defective vision.

So far as infantry are concerned, this is at present chiefly a war of "bombs" and hand and rifle grenades, and a high standard of marksmanship in every individual infantry-man is not essential; some good marksmen are required as snipers, but the company officer always has a sufficient number of men under his command for that purpose. It should also be borne in mind that battalions are as a rule only nine or ten days in the trenches, and are then five or six days back behind the firing-line "resting." As regards artillery, and the requirements of vision of gunners, shooting is always done by map and telephone.

A soldier will not wear glasses unless the benefit which accrues from their wear is very obvious and apparent to himself.

In a large number of cases complaining of their sight (quite 40 per cent. of those tested at the ophthalmic centres at the front in France) it has been found that glasses are quite unnecessary.

It should, however, be remembered that many soldiers of the

New Armies have become so accustomed to use glasses in civil life that they are at a very serious disadvantage without them. The following classes of cases are not, as a rule, ordered glasses :

(*a*) Slight degrees of myopia, under one dioptre.
(*b*) Slight degrees of hypermetropia, two dioptres and under, in men under thirty.
(*c*) Some cases of moderate degrees of astigmatism. Even though astigmatism is shown by retinoscopy, and occasional headache is complained of, glasses are not considered necessary in all such cases; each case must be judged on its merits.—(*Extract from W.O. Letter* 24, *General No.* 4906 (*A.M.D.* 3), *dated* 1587, 14/8/1916.)

It may be laid down, then, with certitude that anyone who has 6/24 vision with one eye, with or without glasses, can do all the ordinary work a soldier can do without any difficulty, but there now arises, however, a further question. If it is permitted to obtain this vision with glasses, as it is in terms of the most recent A.C.I., what does it matter what the man sees without glasses? There is no reason why he should not have a second pair of glasses, and if he loses both he is no worse off than a man with a sprained ankle. The official discrimination between visions of 2/60, 3/60, and 6/60 is in my judgment artificial and not sound. Those who are conducting investigations into the acuity of vision are aware how rough the calculations are. Visual acuity as measured with types depends on the way in which letters are painted—that is, on contrast with the background, on the illumination, and on the size of the pupil; only those who have looked into the matter closely are aware of the extraordinary variations that can be produced by such factors, and the setting of such minimum standards without glasses

is in my judgment quite futile and harmful. The standard I should like to have seen adopted was that adopted by the D.M.S. in 1917, modified to read 6/24 in either eye with or without glasses, provided the other eye is not blind. There is not the slightest doubt that the adoption of these sensible standards of vision would have saved the British Army thousands of men who are otherwise perfectly sound.

Trachoma.—The Army Council decided that cases of trachoma were to be invalided out of the Army at once, and this decision gave a good deal of trouble, for men arrived in Egypt who had been taken into the Army in England with trachoma, and under this decision had to be sent straight back to England and discharged from the Army. There were certainly not very many cases, but there were a few. Experience in Egypt, however, has shown that people with the habits of the English soldier are not at all likely to be infected with trachoma, and infection was very rare in the British Army—in fact, experience in Egypt has shown that infection with trachoma is usually a direct result of the habits of people. A vast number of the Egyptian population and a large number of the Turks suffer from it, and notwithstanding this I doubt whether one hundred British soldiers have been infected with trachoma. It is really a negligible disease, and it is time that the truth respecting its contagious character should be known.

All over the world nations have been legislating to prevent the introduction of patients suffering from trachoma, fearing that, with their entry, the disease would spread to the local inhabitants. The experiences in Egypt has shown that, with an Anglo-Saxon population, the risk is negligible. The spread of trachoma

depends not so much on the presence of patients suffering from trachoma as on the habits of the people.

The following report on the ophthalmic work done in Egypt during 1915 was forwarded by me through the War Office to *The British Journal of Ophthalmology*:

REPORT ON OPHTHALMIC CASES IN EGYPT, 1915

There appeared in the August number of *The British Journal of Ophthalmology* 1917, valuable reports on the ophthalmic work done in Egypt in 1915–1916 by Lieutenant-Colonel Eason, C.M.G., Consulting Oculist, E.E.F., and by Major Lockhart Gibson, A.A.M.C., who was at Mudros in the latter part of 1915 and in Egypt for part of 1916. Both of these reports relate to the period when the work in Egypt was well organized, when appliances were freely obtainable, and when medical assistance was abundant.

1. I propose to complete the story by describing the ophthalmic work in Egypt during the period of improvisation, viz. from the beginning of 1915 until November of the same year when I was invalided out of Egypt. The actual work began on January 24, 1915, at the 1st Australian General Hospital, Heliopolis, where an Ophthalmic and Aural Department was opened, and to which patients speedily found their way. As there was no Ophthalmic or Aural Surgeon available in Egypt at the time, I was appointed Consulting Oculist (and Aurist) to the Force in Egypt, and the greater part of the work was done at Heliopolis. As the year passed by oculists began to arrive in Egypt, and decentralization was gradually effected. The Staff at Heliopolis usually consisted of two or three assistant surgeons, one medical student, and two nurses in the Out-Patient Department, with the use of a ward of 100 beds. The assistant surgeons were mainly Captain Morlet, Captain Stevens, Captain MacLellan, Captain Burke, and Captain Rosenfield, A.A.M.C., with Mr. Cook and Mr. Wharton medical students. The clinic was available, and utilized freely by British and New Zealanders as well as Australian troops. In passing, it may be said that the work was very extensive and heavy, and that there was a considerable amount of operative work after the Dardanelles landing.

2. As regards the nature of the diseases treated, the results were a surprise to those who, like myself, possessed no previous experience of military work. Of the ophthalmic cases, half were cases of ophthalmia, principally of the Koch-Weeks variety, with a smaller percentage of diplo-bacillary cases. There were only five cases of gonorrheal ophthalmia during the whole period; a most remarkable circumstance when the frequency of venereal disease is considered. Errors of refraction comprised nearly 40 per cent. of the cases, so that the cases of ophthalmia and refraction constituted the greater portion of the work, 90 per cent. in all. There were very few cases of trachoma, and nearly all of them came from Australia. It is not a little remarkable that, in a country where trachoma is so exceedingly prevalent as Egypt, practically none of the soldiers contracted it. The circumstance throws a flood of light on the supposed contagious nature of trachoma amongst Europeans, and incidentally on the legislation adopted in the various countries with regard to persons suffering from trachoma.

3. After the landing at the Dardanelles, a fair number of injuries made their appearance, and a considerable number of eyes were excised. A few operations were performed for cataract and the removal of foreign bodies, and in a number of cases projectiles were removed from the orbit. One death occured after the removal of a projectile from the apex of the orbit, and after death a second bullet was found in the brain. Many of the eyes which were excised had not been directly injured, in some cases the projectiles had not passed within an inch of them, nevertheless the internal coats were torn, and the eyes hopelessly disorganised. Whether this arises from the velocity of entry of the projectile or from its rotation, we were unable to decide, but the cases were fairly frequent, and the conclusion certain.

4. *Removal of Foreign Bodies.*—The majority of the foreign bodies in the interior of the eye were non-magnetic, and the eyes were hopelessly disorganized. The large magnet at Mansourah, which is under the control of the Public Health Department, Egypt, was placed at our disposal, but few cases made their appearance in which its use was necessary or of service.

5. *Shell Shock.*—Of genuine shell shock, *i.e.* shell concussion, we saw a few cases. Men who showed no sign of external injury complained of defective vision in one eye and showed

hæmorrhages into the retina. Whether these were due to direct concussion or, as Dr. Mott suggests, due to gassing, I do not know. They were not common, but there were a few definite cases. The remaining cases of so-called shell shock were, when genuine, obviously cases of hysteria, and there were very few of them. A common type of case was the man who screamed at the light, turned his face to the pillow, closing his eyes violently, and of these cases nothing more need be said than that their recovery was usually a matter of a day or two.

6. *Malingering.*—A fair number of malingerers made their appearance at first, and gave a great deal of trouble by reason of the elaborate examination that such cases necessitated. As soon, however, as they realized that an expert department had been created in Egypt, the numbers fell off, and these cases ceased to be of any great importance. There is, however, a type of case much more difficult to handle than the true malingerer—the man with a tendency to neurasthenia or hysteria, who exaggerates his symptoms, and who is subconsciously endeavouring to prove that he is really worse than the medical officer thinks he is. This singular nervous mixture is sometimes very difficult to deal with. There is no sharp line to be drawn between the element of fraud and the element of nervous demoralization. However difficult the problem may be, I am quite convinced that the only mode of treatment which is effective is that based on the absence of morbid sympathy, and based directly on the induction of a normal morality. In these cases the sympathetic lady visitor is apt to be highly dangerous. In such cases, when a complete examination of the eyes showed that there was no disease of fundus or media, and the error of refraction was simple, we disregarded altogether the man's statement respecting his accuracy of vision and discharged him to duty after a reasonable rest, and I think I can say with confidence that in not one single instance was a mistake made.

7. It must be remembered that in the early part of 1915 the issue of spectacles to the men had not been authorized, and arrangements were made at first whereby the men could purchase their own glasses at reasonable rates with opticians in Cairo. Later on, the War Office authorized the issue of spherical glasses. By this time, all concerned had become aware of the fact that it is useless to order glasses for men in the field unless their vision is considerably improved by their use. It also became obvious

to those who watched the work that high-standard vision is not required from modern soldiers. Those who have rendered themselves artificially myopic, as I have done, for the purpose of investigation will be surprised to find how much they can see in the way of common objects with a vision of 6/24ths. I published an account of the investigation of the kind I made in connection with the visit of the British Association for the Advancement of Sciences to Australia in 1914. So far as mariners at sea are concerned, the real danger of defective vision, that is a vision of anything below 6/12ths, is the reduction of the colour sense which follows. 6/12th-form vision would not materially interfere with the activities of people in most occupations, but 6/12th vision and less for pilots or engine drivers may be a very serious matter, because of the great reduction of colour perception with which it is associated. In the case of the ordinary soldier this condition does not arise, and there is no doubt that standards of visual acuity set in the past have erred on the side of stringency.

8. *One-eyed Men.*—It was decided in 1915 to invalid men with only one eye out of the country, because of the supposed risk to the other eye from ophthalmia. We have since learned that the risk of losing an eye from ophthalmia in Egypt is negligible. The policy of sending one-eyed men to the front was dealt with by the Army Council subsequently, but a one-eyed man runs very little more risk of losing his eye in Egypt than he does in England, apart from the risk of active service. He may, it is true, get odd attacks of irritation from the dust, but of serious ophthalmia there is very little risk. One remarkable case came under notice. An Australian who had lost one eye from detachment of the retina determined to go to the Dardanelles. He eluded authority and got to the Dardanelles, was injured in the blind eye and returned to Heliopolis to have it excised.

Summing up the work, it is obvious that the business of an oculist in a war zone does not include the fine work he is accustomed to in civil practice. The greater part of his time is taken up with the treatment of ophthalmia and the cases of errors of refraction, but there is imposed upon him a far greater responsibility than appears in these activities. It is his business to discriminate between the cases which are fit and which are unfit for duty and to see that the cases of hysteria and fraud are

kept in the lines, and that trivial cases are treated at the Front. It is his business to return those who do reach the Base as rapidly as possible. In order to be useful and effect this result, he has to superadd to the expert knowledge gained in civil practice an entirely new and military objective, which calls into being a series of judgments which take time in acquisition, and are exceedingly valuable when once acquired.

CHAPTER X

THE BATTLE OF MARCH 21, 1918

THE previous chapters relating to Standing Medical Boards will have given an insight into the many and complicated problems that are at issue and will have contained a hint, but a hint only, of the far-reaching and national importance of the work done. In Field-Marshal Douglas Haig's report of the battle of March 21, 1918, when the 5th British Army was badly defeated in France—probably the greatest British defeat in history, though now happily redeemed—he points out that the British line was being held by one British division for about 7,000 yards, whereas the Germans had massed several divisions on the same line, with a general numerical superiority of three to one. I have seen it publicly stated, and it was certainly rumoured in Egypt two months before the battle took place, that the British Army was short of men, and the shortage was considered to be 800,000 men; that is to say, there were 800,000 men less than had been estimated to be available. It was supposed to be partly due to the unexpected losses of 1917, but I think there was another and more cogent reason for a portion of such shortage as may have existed.

The following article in *The British Medical Journal* of September 26, 1918, will illustrate:

A PHYSICAL CENSUS AND ITS LESSON

Almost exactly a year ago we gave a short account of the lines along which the reorganized Medical Department of the

Ministry of National Service would work. It seemed to us then that the plan which we sketched in broad terms had been ably constructed and showed a proper appreciation of the medical position and of the part which medical boards should play in the examination of recruits, and we ventured the opinion that the work of medical examination under the new scheme ought to remove all legitimate causes of grievance. We are now able to give some indication of the results of the physical examinations undertaken during the first eight months of the present year, and of the message they convey as to the physical fitness of the British stock.

Between January 1 and August 31, 1918, the number of medical examinations conducted by National Service Medical Boards in Great Britain amounted to 2,080,709. During this period 28,035 applications (that is, 1·34 per cent. of the examinations) were made to appeal tribunals for medical re-examination, and of these applications less than a half were held by the tribunals to rest on grounds sufficiently substantial to justify the granting of leave for re-examination. Further, of the applicants who were granted leave to be examined by the medical assessors of the Local Medical Board, the grading of 50 per cent. was unchanged.

In other words, in less than 4 per cent. of this enormous number of medical examinations there was reason to believe (so far as the evidence afforded by the organization of appeal tribunals goes) that the grading by the National Service Medical Board did not correctly represent the degree of medical fitness of the individual. This result may be expressed by the general statement that a National Service Medical Board, working full time and examining twenty-five men per session of two and a half hours, graded one man per week incorrectly.

In order to realize the vast amount of work that has been done in this direction by the medical profession since the beginning of this year, it should be remembered that the administrative machinery was not created until November 1917, and that the examinations have been carried out during a period in which unprecedented strain was thrown upon the profession to meet the heavy and persistent demands of the fighting forces for medical personnel. Moreover, the work has been done in a country to which the whole idea of conscription was novel and distasteful. The working of the administrative machinery of a

compulsory Military Service Act in its application to the individual had never been envisaged, and the difficulties arising from the consequent mental attitude of the population were much intensified by the raising of the general military service age to fifty-one in April, which greatly increased the perplexity of the domestic, occupational, and medical problems, and appeared to threaten the whole fabric of the national structure. The problems of grading had never been thought out, while the details of the procedure, and to a less extent the methods of examination, were new and unfamiliar. That in such circumstances the average error should be represented by a fractional percentage constitutes a record of which our profession has every right to be proud, as well as those responsible for the creation and administration of the machinery necessary to perform this work upon an organized basis.

There is another and more important aspect of this work. Of the two million men examined, not more than 36 or 37 per cent. were placed in Grade "I"—that is, approximately only one in every three had attained the normal standard of health and strength, and was capable of enduring physical exertion suitable to his age; the remainder—more than a million and a quarter—did not reach this standard. The suggestion has been made that the low proportion of fit men among those examined during this period is due to the fact that only the leavings of the population were under review. Analysis of the records available, however, shows that this is not the case, and that as a fact the men examined constituted a fair sample of the male population between the ages of 18 and 43 and a smaller proportion of the more fit between 43 and 51. We are told, further, that the experience of the Boards medically examining women for national work corresponds broadly to that of the National Service Medical Boards examining men. Such evidence points only too clearly to a deplorably low state of national health.

While it has not yet been possible to work out the details of this great mass of medical examinations, the preliminary results indicate that preventable disease is responsible for the bulk of these physical disabilities, and demonstrate the ravages which industrial life has made upon our real national capital—the health and vigour of the population. Too little food, too long hours of work, too little sleep, too little fresh air, too little play, too little comfort in the home, are evidently the chief factors

concerned in producing this mass of physical inefficiency with all its concomitant human misery and direct loss to the country. To take effective measures on the broadest lines to remedy this condition of things is a most urgent duty. It is not necessary to wait for the end of the war. The war has revealed the defect, but it has also led to the suggestion of remedies, as may be read in the reports of the Health of Munition Workers Committee. It was mainly for this reason that it seemed well from time to time to devote a good deal of our scanty space to these reports. They were written to meet an emergency, but contained much of permanent value in relation on the one hand to hours of work and industrial fatigue, and on the other to what is commonly called welfare work—that is to say, the application of sound medical and hygienic principles to the care of the health of workers. The State in the future may do something, especially in relation to the last of the evil influences enumerated above, for it seems to be acknowledged that the capital necessary for proper housing cannot be provided by private enterprise; but the remedy for the other evils must be sought in a closer and more friendly understanding between employers and employed. Dr. Rhoda Adamson's article published last week (p. 309) shows that it is by no means hopeless to expect employers to respond to a reasoned appeal. Although real improvement can hardly be expected for one or two generations, the foundations of a better national physique can be laid at once.

This leading article in *The British Medical Journal* appears to me to be remarkable. In the first place, if only one man in every three was regarded as fit for general service, there was not much reason for appealing from the decision of the Boards, and it is difficult to understand any jubilation about the success of this Boarding system when two-thirds of those examined were placed lower than Grade "I."

The inference drawn by the writer, too, that the physical conditions in Great Britain show evidence of serious deterioration depends entirely on what standards those Boards adopted.[1] We have already shown

[1] Chapter v.

in earlier chapters our estimate of the physical condition of the men who were not Grade " I " who reached Egypt, and were allotted to Garrison Battalions. Had the visual standards in Great Britain been those adopted in Egypt by the D.M.S. on the advice of the Consulting Oculist in 1917, and had all cases of otorrhœa which were not deaf been placed in Grade " I," if they were otherwise physically fit, it is quite safe to conjecture from the Egyptian experience that many thousands of men would have been added to Grade " I " in Great Britian. If the remaining Egyptian standards had been adopted—and be it remembered that when tested they were found to be satisfactory under the most severe conditions in the desert—it is possible that a far larger percentage of Grade " I " men would have been obtained from the recruits examined in Great Britain, and in that event the British Army might not have been defeated on March 21, because its reserves might have been, and probably would have been, ample. Two hundred thousand men would have made all the difference. I submit, then, with proper respect, that it is a matter for national consideration whether a proper inquiry should not be made to determine whether the defeat of March 21 was not primarily due to the standards adopted by the medical Boards in Great Britain, and if so, who was responsible for the fixation of those standards. Were they medical officers who had served abroad and were acquainted with war conditions, or were they medical officers who had served at home and were not so fully aware ?

There seems to me to be on the evidence furnished in Egypt an *a priori* case for judicial inquiry.

It is, perhaps, not amiss at this stage to remind readers

of the essential difference between the conditions in France as they are reported to have existed, and the conditions in Egypt as they are known to me, so far as hardship is concerned. There seems little doubt that in France a soldier is more likely to suffer from gunshot wound, and that the work in muddy trenches in Flanders was very trying, but when he was out of the trenches the conditions were not so severe, and leave to England was always possible. In Egypt there was no mud, but there was intense heat, months and months were spent in the desert, and leave to England was impossible; and whilst the risk from gunshot wound was not so great as in France, though quite great enough, the risk from dysentery, malaria, and the like was very serious, as the last acts of the campaign show. Any man who went through four years' campaigning in Egypt and Palestine, and came out unscathed at the end of it, could regard himself as fortunate.

SECTION III

THE MANAGEMENT OF VENEREAL DISEASE

CHAPTER XI

THE PROBLEM OF VENEREAL DISEASE

The damage done during the war by venereal disease has been enormous, and some indication of the gravity of the problem and its difficulties will be afforded to anyone who will glance through the references to the matter in a book published by Lieutenant Deane and myself called *The Work of the Australian Army Medical Corps in Egypt in 1914–15*. The matter is also dealt with in my own work, *The Twin Ideals*.

In Egypt the matter has undergone three phases:

When I was A.D.M.S. to the Australian Force in 1915, the most active efforts were made both in the moral and prophylactic direction, and the work done is referred to in the chapters referred to. When I ceased to be connected with that Force, and was invalided to England in November 1915, for some time no one took my place. During this interregnum the troops returned from the Dardanelles and the conditions in Egypt were such as to force the appointment of a military and civilian committee, known as the Cairo Purification Committee, presided over by the Inspector-General of Communications, E.E.F. This committee

took extensive evidence from medical officers, chaplains, and others, and elicited the remarkable information that in April 1916, in one section of the forces, the admissions for venereal disease were at the annual ratio of 25 per cent. (The figure was really higher.) When it is remembered that there may be a good deal of concealment of venereal disease, some idea of its incidence may be gained. The average annual rate in this month for the whole Force was about 12 per cent. As usual, once attention was directed to the matter, it began to decline. The committee recommended that a number of steps should be taken, including the appointment of ablution tents to which men could repair immediately after exposure. The disease steadily fell in frequency, and at the end of 1917 had attained small proportions. Again attention rather slackened, the troops advanced into Palestine, and another serious outbreak took place. Again the military authorities made careful inquiries, and loosed a campaign both on the moral and prophylactic side which had the effect of again holding the disease in check. Like some other medical arrangements in Egypt, the control of venereal disease resembled the movements of an accordion.

In addition a remarkable piece of evidence has been obtained. At the outbreak of war, Lieutenant-Colonel Elgood, C.M.G., was appointed Base Commandant at Port Said, and did the heavy work attached to that position until the end of the war. As he frankly admitted, at the outset he had no practical knowledge of the ravages of the disease, and the mode of controlling it. He set to work and made a determined attempt to control the disease, which is described in the following statement:

PORT SAID UNDER MARTIAL LAW

A declaration of martial law restricts the liberty of the inhabitants of the country on which it is imposed. Business is impeded; travelling is interfered with; private property is requisitioned; and in a word normal existence is often sacrificed to the military exigencies. On the other hand, it becomes practicable to remedy, or at least to palliate various abuses neglected by the Civil Administration; particularly when the abuse affects the health and well-being of the troops. Handicapped by the existence of capitulations, no less than by the apathy of the inhabitants of Egypt, the Anglo-Egyptian Government constantly has found itself powerless to reform the abuses which touch neither the person nor the pocket of the resident of the country. The notorious immorality of Port Said is a typical case in point; and it may be of interest, therefore, to describe briefly the measures initiated under martial law to remove this stigma.

I shall frequently have to speak as if the experiences were purely personal, but I claim no credit for any improvement effected (indeed at times I am reminded painfully of how much has been left undone), and I use the personal pronoun only to undertake the responsibility for the many errors of judgment which have been committed.

Such expressions as a "sink of iniquity" or "the finest example of hell on earth" have been applied frequently and with some justice to Port Said. No doubt, within recent years, the more blatant sores have been removed by the Civil Government. For example, the gambling dens opened to the public disappeared some time before the war; but very little change for the better had taken place in the underworld. The Port still remained a centre of the White Slave Traffic. Unfortunate girls would remain here a few weeks or months, and then be transferred (or exchanged with other women) to the Far East. The transaction was purely commercial, and the girls were treated as so much merchandise.

The civil police harassed this traffic in human flesh to the best of their ability; but it required the perusal of letters (possibly only through the censorship established in the early days of the war) which were exchanged between the procureurs to realize the horrors of this terrible commerce. Hotels of ill

fame and brothels abounded in the European Quarter of the town. In these dens, every form of vice known to the modern world was practised. The women in the first place were subjected to no medical examination, and undoubtedly many must have been infected with venereal disease. Pimps and touts, employed by the hotels and brothels, hung about the main streets and the entrances of the residential hotels. It was very difficult indeed to walk out after dark without being accosted by more than one of these gentry; and chaplains have complained indignantly to me that even their cloth did not afford protection from the unwelcome attentions of pimps. Indecent and vilely obscene photographs were procurable in many shops at small cost, and were sold publicly without risk to the vendor. Such, briefly, were the morals of Port Said in the autumn of 1914.

On the declaration of martial law in November 1914, I pressed upon the civil police the necessity of exercising more control over the public women in the European Quarter. Apart from any consideration of decency, it was clear that troops presently would occupy the town, and in consequence that measures must be taken with reference to these women. The Commandant, Suez Canal Police, acted with promptitude. He closed the brothels, and ejected their inhabitants. The hotels were less easy to deal with. The managements protested vigorously against our action, appealing in certain instances to their consular authorities for protection. The consuls, however, paid no attention to the outcry, and the hotels were closed.

The next problem confronting us was the disposal of the women. About half their number decided to leave Port Said, the remainder (say forty) refused to budge. After some consideration the solution was found, and the women were housed, with their own consent, in the Arab Quarter, where a district was set apart for their convenience. This decision solved a second difficulty incidentally; for Port Said is divided sharply into two quarters, the European and the Arab. No objection was raised by the inhabitants of the second to our decision; and since all native prostitutes by law were bound to reside in the Arab Quarter, by including in that regulation prostitutes of a European origin it became possible to exercise not only police but also medical control over both classes of public women. Under the direction of the Public Health Department,

Egyptian Government, a weekly examination of licensed women is made. Those found free from the disease received a card marked "Saine"; those infected were sent for treatment to hospital. Incidentally it may be remarked that the term "Saine" is a little misleading. It would be more correct to substitute for "Saine" the word "Examinée"; and in these circumstances, no man consorting with a licensed prostitute could complain that he had been deceived.

While these measures were being undertaken, Indian troops arrived on the Canal. Port Said held a brigade, and the Arab Quarter was placed "Out of Bounds." This order had no connection with prostitution, but was issued in consequence of some doubt being felt at that moment whether reliance could be placed on the loyalty of the Egyptian residents of Port Said. It was decided, therefore, that the Indian-Moslem troops should not be exposed more than was necessary to possible elements of disloyalty. In any case, I confess that I felt no uneasiness in troops consorting with women of the Arab Quarter: for at that period I was under the illusion that, given a satisfactory medical examination of the women, no reasonable risk of venereal disease infection existed. Twelve months later, however, the Indian Expeditionary Force was merged into the Egyptian Expeditionary Force. Port Said became the Head-quarters of an Army Corps as well as a Base. A division of infantry and of course a number of Base troops were quartered in the Area. The Arab Quarter remained "Out of Bounds"; but with the limited force of military police at my disposal, I was totally unable to enforce my own orders at first. Again, however, I was not greatly concerned; and it was not until the middle of 1916 that I became vaguely aware of the insufficiency of the medical-examination system. But it was apparent to me about that period that the incidence of venereal disease among troops in No. III Section, Canal Defence (*i.e.* Port Said to Kantara) was relatively high; and, unless I had misread the signs, was growing higher. I ascribed that fact to the inclination of the troops to spend their short leaves in Cairo rather than at Port Said, where I felt confidence in the medical examination. That assurance, however, was rudely shaken by the establishment of the fact that individual soldiers would visit a particular brothel whose inmates were under medical inspection, and yet contract the disease. I made it my business to invite

patients to give me the names of the women, and house, with whom they had associated. In many instances I obtained the woman's card. The Public Health Department was requested then to make a special examination, and further to take a microscopic slide. In every case, without exception, the result both medical and microscopic was negative. Either all these soldiers, therefore, were lying deliberately, or certain dependence cannot be placed upon medical examination.

The Commander-in-Chief at this period spared no pains to impress upon all ranks the importance of diminishing the incidence of venereal disease in the E.E.F. He directed the publication of several memoranda dealing with the subject, wherein he desired all commanders to draw the attention of their men to the ethical side of the question, and the effect which the disablement of men otherwise fit must produce upon the fortunes of the war. How far these appeals of the Commander-in-Chief were successful or not is difficult to estimate. In my own case I assembled all officers of the Base, and expounded the views of the chief; but I do not think that I enlisted the sympathies of my audience. Senior officers suggested that I should do better to place the Arab Quarter in bounds, and concentrate my efforts upon improving the weekly medical examination of the women; but apart from an increasing distrust of the value of such inspection or examination, I was well aware that the Arab Quarter panders to other and more depraved methods of sexual gratification. To attempt the moral regeneration of the Quarter was beyond my own powers; but it was my duty apart from all question of reducing venereal disease to protect young soldiers from contamination with such perverse forms of vice.

It has been said that the Commander-in-Chief directed that in any consideration of the problem insistence must be laid invariably upon its ethical side. His belief in the latter as a factor was demonstrated by his forming a Purification Committee in Cairo with sub-committees in other towns. The Chairman of the Cairo Committee was the Inspector-General Lines of Communication, and I venture to think that the report signed by the majority of his committee is an extremely sane and moderate pronouncement. The Port Said sub-committee proved a useful consultative body. I learnt personally much from some of its members. The medical representatives confirmed my own doubts as to the complete efficacy of the medical

examination, whilst establishing the fact also that without some such control matters would be much worse. One lay member argued that once the decision had been taken to define the quarter wherein prostitutes were authorized to carry on their calling, that principle should be applied also to all women in Port Said who were convicted of immorality. I was unable to accept such a proposal, even if it had been in my power to carry it out. I could not forget that our action in Port Said had been directed chiefly against the person of the woman; and to incarcerate one in the Arab Quarter because she had made an occasional slip of virtue was to condemn her in fact to social damnation from which there was no escape.

As elsewhere, indeed, there exists in the town a number of women who are prepared to become the temporary mistresses of men willing to pay for the privilege of supporting them. Thus the artistes attached to the music halls may be included fairly in this category. There are others also, such as sempstresses, who supplement their scanty wages by gratifying the sexual desire of some chance man. But in such instances it is the man who hunts the prey, and not, as in the case of the professional prostitute, the converse. That fact, therefore, was an additional argument in my judgment against any action with regard to this class.

It was elicited meanwhile that various conveniences admitting of illicit intercourse between troops and women had sprung up in the town. The hotels of ill fame which had flourished in the past were being replaced, in fact, by less pretentious, but equally vicious establishments, wherein rooms were let for an hour or two. There appeared to be no reason why these houses should be tolerated in the European Quarter, and the civil police took immediate steps to close them. No doubt, others are still open; but the owners can take no risk to advertise their use, and the trade is attended with some risk.

A second member, an old resident of Port Said, called attention to the number of touts and pimps infesting the town. In his view, owing to the compulsory extinction of all artificial lights, troops would be unable to find their way to the Arab Quarter after dark, if it were not for the guidance of a tout. His argument seemed reasonable, and instructions were issued to the military police to arrest pimps who were observed to be practising their trade. Apart from the question of the Arab Quarter,

I felt considerable sympathy with many officers who had complained from time to time to me of the annoyance caused by these gentry. The difficulty in the past had been to devise a procedure whereby pimps detected in *flagrante delictu* could be punished. The civil law was powerless; but the institution of Summary Military Courts about this period offered the desired means. Later, it transpired that such Courts also were incompetent to punish pimps, and in consequence, though with great reluctance, I had to abandon any further proceedings. Fortunately I did not become aware of the illegality until several offenders had been found guilty and punished. The pimp not only has been frightened, and is practising his profession with greater caution; but by some administrative measures, I am glad to believe that his activities are now greatly hampered.

It need hardly be said that a flourishing trade in the past at Port Said was that connected with the sale of liquor. In the early stages of the military occupation of the town, soldiers arrested for being drunk frequently alleged in excuse that the alcohol was drugged; but vile as the liquor may have been, I do not believe that to be the case; for of the many samples taken and dispatched to Cairo for analysis, no sample was returned as such, though very many were declared entirely unfit for human consumption.

Drunkenness, however, continued to increase, and early in 1916 it was apparent that drastic measures must be taken. Many of the units then encamped at Port Said had disembarked directly from the Dardanelles. Some of the troops, after six months' arduous trench work, imagined that at Port Said they would have full licence, and the owners of the various bars and restaurants assuredly did their best to foster that belief.

A Proclamation under martial law had been issued shortly before placing the control of the sale of alcohol in the hands of each local commander. The effects of this Proclamation have been far-reaching; no more widely than at Port Said. I am not a supporter of total prohibition; but I spent too many years in the old army to fail to appreciate the pernicious result which unrestricted opportunities of obtaining alcohol have upon men who have not attained maturity. In Egypt it is an unfortunate fact that licence to sell liquor is relatively easy to obtain, and Lord Cromer and many experienced Anglo-Egyptian Administrators have deplored the quantity of alcohol

imported into this once so temperate country. From both the military and the civil points of view, therefore, I had no hesitation in availing myself of the powers conferred by the Proclamation, and I restricted the sale of alcohol to the hours of 1 p.m. to 3 p.m., and 6 p.m. to 9 p.m. Drunkenness showed, at once, a sensible reduction; but while all respectable houses of entertainment obeyed loyally the regulations, less reputable establishments sought, and still seek, every opportunity to evade them. In the circumstances, it is not easy to obtain proof of any offence, but I have overcome the difficulty to a certain extent by placing "Out of Bounds" any bar or restaurant wherein a naval rating or soldier is perceived to show signs of intoxication. The same penalty is exacted if the Medical Officer of Health, Port Said, reports that the sanitation or cleanliness of a bar or restaurant is deficient; but in such a case, the owner is given fourteen days' grace to comply with the Health Department's conditions.

Some little time elapsed before the Naval and Military Authorities of all Allied Nations agreed that the order "Out of Bounds" affixed to the establishment would be respected equally by them; but eventually the point was conceded. The concurrence of all authorities was important, for since many months most of the Allies have been represented at Port Said by permanent detachments of sailors and soldiers.

The connection between venereal disease and restrictions upon the sale of alcohol may appear to be slight; but as I hope to demonstrate later, the second exercises considerable influence upon the first. I have taken the pains, therefore, to describe at some length our measures at Port Said to limit drink. I have reason to believe that the regulations are considered to be too drastic by many people. At least scarcely a week passes without some individual whose position entitles him to respect approaching me with the suggestion that the general sobriety of their troops and their excellent behaviour in the town deserve better recompense. The more respectable civilian residents also feel that their comfort and pleasure are seriously curtailed by these restrictions. I concede willingly the truth of these arguments: but none the less I do not see my way to relax any of the measures taken.

Notwithstanding that the Arab Quarter is picqueted and patrolled by the military police, as far as the slender resources of the Port Said base allow, it requires no great ingenuity on

the part of any soldiers caring to run the risk to enter and leave the quarter undetected. Nor is it possible for the civil police to prevent the native public women plying their trade on the sea beach. In fact, I had been aware for some time that both of these practices are common.

Fortunately, however, at this stage, I came into contact with Colonel Sir James Barrett, K.B.E., R.A.M.C., and of Miss E. Rout, New Zealand Voluntary Sisterhood. The first suggested that the solution of the problem would not be found in police measures or in medical examination, but in prophylaxis; while the second in correspondence relating her own experiences gained in England encouraged me to advocate this remedy. It must be confessed that the men and women of Australasia regard this distasteful subject with greater frankness and with less timidity than Great Britain does. If the figures which from time to time have been shown to me are correct, Australia and New Zealand have good reason to feel anger at the conventionality which forbids in England any discussion upon venereal disease.

Figures and facts have produced in me the conviction that in these abnormal days we must rely upon prophylaxis to fight this insidious malady. I have no intention of surrendering any of the police or medical measures which I have attempted to describe in the preceding pages; and the fact that troops are forbidden to frequent the prostitutes' quarter, and yet in their camp are provided with prophylactic treatment, is an anomaly which does not deter me from advocating the employment of the latter. So, too, in the twentieth century A.D. is war an anomaly. Yet the entire civilized world at this moment is entangled in the paradox: and, reckless of sacrifice of blood and money, men are determined ruthlessly to pursue war to its bitter end. If men in spite of orders to the contrary, and in spite of punishment in event of detection, persist in consorting with loose women, I maintain that it becomes the primary duty of all thoughtful persons to take what steps they can to protect the wives, or the girls who will become the wives, left at home from risk of later infection at the hands of their men.

In August of this year, a permanent Camp of Rest was formed at Port Said for the Mounted Corps, E.E.F. A large proportion of the men belonged to the Australian Imperial Force. These troops have been fighting and marching for more than twelve

months; many have had no leave during that period, and no relief from the wearing monotony of the desert. If any troops would be likely to indulge in excesses, it would be men who have endured such conditions. Up to date, 9,282 all ranks have stayed in this camp, some for a period of eight days, others for fourteen, and individuals much longer. Venereal-disease infections have been carefully noted. They number thirteen in all, whether the malady shows itself in camp, or on the return of the man to his unit. It is not possible to guarantee the absolute accuracy of the number of the venereal-disease infections, but very great care was taken to keep count of them.

I have reason to believe that the majority, if not all, of the infected failed to make use of the prophylactic treatment provided, owing to their being under the influence of drink. Well may each of these unfortunates ask, as did the Roman poet, *Quo me, Bacche, rapis tui Plenum?*

It may be of some interest to describe briefly the prophylaxis practised in this camp. There are three conditions, viz.:

(*a*) Thorough washing externally with 1 in 1,000 perchloride.
(*b*) Irrigation of the anterior urethra with pot. permanganate, 1 in 3,000. The apparatus used consists of an elevated glass container with rubber tubing, clip, and glass Y-piece nozzle.
(*c*) Calomel ointment applied, and bandages furnished to keep the ointment from soiling the clothes.

The numbers availing themselves of prophylaxis have been 4,580, or approximately 50 per cent. of the men attending the camp. It seems reasonable that possibly one-third have made use of the treatment on more than one occasion: or in other words, that (say) one-third only of the total visitors at the camp have had sexual relations with women during their stay at Port Said. A legitimate deduction therefore from that hypothesis appears to be this: some men are deterred from visiting the Arab Quarter in consequence of the locality being "Out of Bounds."

The figure of 4,580 is certain: for in this case there has been no difficulty in counting (names are not taken) the number of men daily using the prophylactic tent. To my mind, the fact

that less than half of the 9,000 all ranks availed themselves of treatment affords ample justification for the restriction placed upon the Arab Quarter. I argue this. It is clear that few of the remaining 50 per cent. had intercourse with women, and yet did not visit the tent, or inevitably in existing circumstances the venereal-disease infections would have exhibited a very much larger incidence. If therefore we make a liberal allowance for men who have remained continent during their period of rest from some ethical or even æsthetic motive (for the surroundings of the Arab Quarter repel the fastidious), there must remain a residue quite unswayed by any such argument. But in all bodies of soldiers there exist individuals who regard an unblemished defaulter sheet as their most prized possession.

Unlike ethical motives, which tend to lose force with every month the soldier is kept from home, the desire to retain at all costs a "Clean Sheet" grows stronger as the soldier's period of service in the field is prolonged. Such men will not imperil their record by any conflict with the military police; and they respect the latter's orders. What is the number of men to whom such a consideration applies cannot be estimated. Nor am I personally concerned with any speculation of this nature. I am satisfied that the consideration exists; and even if it were demonstrated that as a consequence twenty men only were deterred from visiting the Arab Quarter, I would think still that the restriction was justified.

Signed: P. G. Elgood, *Lieutenant-Colonel.*
Base Commandant.

Port Said,
December 31, 1917.

This report is to me one of the most valuable documents in existence, because I know from personal experience the thoroughness with which these measures were adopted. Furthermore, at the time when he thought his sentries were efficient, I became aware that they were being eluded by the ingenuity of the women and those who wished to have intercourse with them; in fact, I do not know of a more impressive instance of the impossibility of wholly suppressing this traffic

by the use of force. When I acquainted Colonel Elgood with what was going on, he discussed the matter very earnestly with me, and asked whether I would suggest that he should relax any of the disciplinary measures he had taken. I replied that were I in his place I would not relax in the least, but I would add prophylaxis, and make every effort to supply the social wants of the men. It only remains to add that when the typhus epidemic broke out in 1918, and Arab Town was placed out of bounds, the soldiers no longer reported at the ablution tent, as they thought they would be punished for having got into Arab town—in other words, that the fact of their reporting indicated that they had been there—with the result that venereal disease immediately increased.

In conclusion let me ask any dispassionate reader whether, instead of this administration by oscillations and meetings of committees it would not have been better to have created a new appointment, and to have appointed an A.D.M.S. or Consultant, whose sole business would have been to investigate and advise on the subject of the control of venereal disease. Such an officer would have been constantly travelling, he would have met the officials in the different districts, would have become aware of the difficulties of the problem, and would probably have steadied the administration and minimized the damage.

But such an appointment would have been an innovation, and difficult to make. It would have been necessary to persuade not only the Medical Staff, but the Finance Committees of the War Office, that a service which had never before had such an officer now required one. It would have been quite easy, however, to take an officer out of the hospital and give him the

work to do, provided he was not given definite rank, status, and pay. The delay in making these necessary appointments in war-time arises from the cumbrous nature of the official machinery rather than from the desires of the administrative officers themselves.[1]

[1] A supplementary account of the management of venereal diseases in Egypt appears in *The British Medical Journal*, February 1, 1919.

SECTION IV

THE RELATIONSHIP OF THE RED CROSS TO THE ARMY MEDICAL SERVICES

CHAPTER XII

THE R.A.M.C. AND THE RED CROSS

During the war the British Red Cross Society has been of considerable service. It has, I understand, collected from one source or another some fourteen millions of money, and has expended it for the benefit of sick and wounded soldiers.

It may be as well to inquire what is its organization, what are its functions, and what is its relation with the R.A.M.C. In the book published by Lieutenant Deane and myself called *The Work of the Australian Army Medical Corps in Egypt*, extensive reference is made to this subject, but some recapitulation is desirable.

Its government is unusual. It is managed by a Committee in London, self-appointed and filling up vacancies by co-option, the representative principle being wholly absent. This Committee appoints Commissioners in various parts of the world who are to all intents and purposes autocrats, subject only to the Central Council in London. Advisory Committees are appointed, however, by these Commissioners who possess no powers of administration or control, who are

not consulted respecting expenditure, respecting appointments, and only occasionally respecting policy. The Committees serve the purpose, however, of reassuring the public respecting the proper working of the Red Cross system and do assist in diffusing a certain amount of interest and information. They are also of very great service when appeals for funds are made. If, then, application be made to the Red Cross Commissioners for assistance by officers commanding hospitals, it rests with the Commissioner to assent or refuse, as the case may be; and though in general they work in friendly association with the officers administering the R.A.M.C., the fact remains that there are two sources of supplies and two independent controls, viz. the Military and the Red Cross. As regards the functions of the Red Cross, they have been well expressed by Sir Henry MacMahon, who, when High Commissioner in Egypt, described them as follows:

> Government supplies all the necessities for the care, treatment, and transport of the sick and wounded, while the Red Cross supplements these necessities by everything that can in any way go to the comfort and well-being of the sick and wounded soldiers. The distinction between necessities and comforts is sometimes so indefinite that the Red Cross, wherever possible, endeavours to have both ready to hand for use when needed.

And later:

> A word must be said here about the work of the Red Cross Stores. The object of the Red Cross has never been to supply in any large quantities the goods which the War Office sends to the wounded, but it does its best to provide the troops with such things as the War Office does not supply at all or cannot supply at a given time. A State Department, bound as it rightly is by hard-and-fast rules, cannot work as quickly as a private body with more elastic regulations; moreover, the supplies of any department may change at times, hence it happens that the

British Red Cross occasionally supply certain things more than the War Office can, or it may supplement the War Office supplies, and it does so until the War Office steps in again. Further, the Red Cross supplies many things or small luxuries which the authorities cannot possibly supply, and these are just the things which are most appreciated by the sick and wounded.

The Red Cross, apart from furnishing supplies, did considerable service in establishing bureaus for inquiries relating to the sick and wounded. It further partially arranged convalescent outings, and gave a certain amount of personal attention to the soldier; but over and above these desirable activities, it showed a tendency to undertake functions which belong to the Army Medical Service, as, for example, the organization and administration of hospitals, and motor ambulances. In the book published by Lieutenant Deane and myself, *The A.A.M.C. in Egypt*, this aspect of the matter has been discussed, and there is no need to refer to it again at length. There are, however, so many activities which might be accomplished by those who possess vision that a well-staffed Red Cross will always be of service, but it must be administered by highly educated men endowed with scientific imagination.

The personnel of the American Red Cross was arranged on a different plan from that of the British Red Cross. It included medical officers and nurses and was administered by an educationalist, but the special function of the American Red Cross in Egypt was, by arrangement with the British Government, to take over the medical care of the destitute population in Palestine, and it was accordingly organized for that special purpose.

The Chief Commissioner of the British Red Cross in Egypt was attached to the Staff of the Commander-in-Chief, and consequently the Red Cross was theoretically

in some measure under discipline, though practically it was not, for as one Commander-in-Chief said to me, "If I were to find out that the finances of the Red Cross had been wrongly handled by a military officer who happened to be doing work for the Red Cross, I do not think that it would be directly my business to interfere."

It will therefore be seen that the British Red Cross is largely an amateur organization, built up on voluntary lines, managed by an autocratic committee, and conspicuous by the complete absence of the representative principle. Let us ask ourselves, why should the Red Cross undertake any single function which the Army Medical Service can discharge? In 1914–15 there was a very good reason why it should, as the Army Medical Service was not equal to the task imposed on it; but when the Army Medical Service established hospitals, built hospital trains, hospital ships and the like, why should the Red Cross have continued to administer anything the Army could accomplish? Surely the purpose should have been to provide the extra comforts which the Government does not think necessary or right to provide. There is something to me entirely wrong in the administration of hospitals by two systems; the point was exemplified acutely by a Red Cross Commissioner in Cairo, who spoke with pride of the Red Cross Hospital at Ghizeh, to which he stated the men preferred to come because the discipline was easier than at the Army hospitals in Cairo, and the food was better. From this position, then, there is no escape: either the Army hospitals were wrongly administered, or the Red Cross hospital was; but invidious distinctions of this kind are not good for the service.

The Japanese have long since dealt with this par-

ticular phase of the problem, and those who wish to assist the Japanese Army do so by supplementing the work of the Army Medical Service.

An interesting work has been published by an American who was in Germany during a part of the war, called *Lessons from the Enemy*, by McDill, in which full details are given of the colossal work of the German Red Cross, and of the way in which vast numbers of nurses and other medical workers were trained in times of peace.

Surely a proper solution of the relationship is that the Red Cross should continue as a voluntary organization in times of peace, but on a representative basis and containing in its governing body *liaison* officers from the army, who should help and guide it, that when war is declared the whole should be incorporated in the Army Medical Service, and the Chief Commissioner become a member of the Staff of the Director of Medical Services. To put it quite plainly, the Red Cross as it exists in England is a relic of the voluntary and amateur spirit which has been present throughout the empire, and which has many advantages as well as most serious disadvantages. I think the feeling of the majority of medical officers who have served through the war may be expressed much as follows: whether it is really worth while to continue as a voluntary association an organization which with all the advertisement, with all the emotional appeals, and with all the efforts used to raise funds, in England and Overseas, has only raised funds equal to two days' expenditure during the war.

If the various activities represented by the Red Cross over and above those undertaken by the Army Medical Service are considered right and proper, if the extra

supplies over those the soldiers officially receive are passed as right and proper, would it not be better to nationalize it? Would it not be better to let this relic of the voluntary system drop into its proper place and become an organic part of the life of the nation? At present a wholly disproportionate estimate is apt to be made of the extent and value of the service rendered.

A book was recently published, called *The R.A.M.C. in Egypt*, by "Sergeant-Major," and at the end of the book the following quotation is made from an utterance by Sir Courtauld Thompson, Chief Commissioner for the Red Cross in Egypt:

> It is due, however, to the officers and men of the official organization (R.A.M.C.)—such a statement can in no way detract from the praise due to the voluntary societies—to record here exactly what proportion the work of the societies bears to the whole volume of achievement which is to be placed to the credit of the British Medical Service in Egypt. This may be accurately set down as about 3 per cent. The estimate is not "official." The figure indeed is quoted from a speech delivered by Sir Courtauld Thompson, the Chief Commissioner of the Red Cross combined organizations in Egypt; and may therefore be taken as unimpeachable. At first such a figure applied to the work of these societies may appear disappointingly astonishingly small. It is not, however, really so. A percentage is only a relative term. We are not dealing in this case with 3 per cent. of a molehill, but of a mountain; and in that degree of estimation the work of the Red Cross Society can only be regarded as magnificent from whatever standpoint it is viewed.

At this meeting someone said that the R.A.M.C. did 97 per cent. of the work and got 3 per cent. of the advertisement, whereas the Red Cross got 97 per cent. of the advertisement and did 3 per cent. of the work.

I take it that if the system were placed on a national

basis, neither party would wish to get any advertisement other than that accruing to all men who try to render loyal service to their country in time of need. Nothing is more certain to my mind than the necessity for a careful, dispassionate, and sympathetic revision of the relationship of the R.A.M.C. to the Red Cross, and in making the necessary investigation much will be obtained from a study of the corresponding institutions in Japan and in Germany.

SECTION V

THE REORGANIZATION OF THE R.A.M.C.

CHAPTER XIII

WHAT IS THE ORGANIZATION OF THE R.A.M.C. ?

The R.A.M.C. organization before the war appears to have been, like the British Army itself, conducted on a limited scale, both with regard to numbers and to scope of work. It contained apparently about 1,000 officers distributed in various parts of the world—that is, a smaller number of officers than have been employed in the Egyptian campaign alone.

In Egypt there has been a Director of Medical Services (D.M.S.), whose position is always close to the General Officer Commanding-in-Chief, whether the General Head-quarters (G.H.Q.) happened to be in Cairo, at Ismailia, or in the forward areas, and his authority in all matters medical is practically absolute. He is responsible to the Commander-in-Chief and to the Director-General of Medical Services, who again is attached to the Army Council in London, the Army Council being the supreme governing body of the Army under the Secretary of State for War. In addition the E.E.F. has been divided into three sub-commands, namely: Alexandria and the Western Desert, Cairo and the Delta District, and what is known as Palestine Lines of Communication (L. of C.). Each of these sub-commands is presided over by an Assistant Director

of Medical Services (A.D.M.S.), who is associated in like manner with the General Officer Commanding the District, to whom he is responsible as well as to the Director of Medical Services, G.H.Q., E.E.F.

These three districts have varied a little from time to time in geographical extent, but roughly comprise the following areas :

A.D.M.S. Alexandria had for his sphere of influence Alexandria and the North-western Desert as far as the frontier of Tripoli.

The Delta District included Cairo and the whole of Egypt proper west of the Canal, including Suez, Ismailia, and Port Said, but not Kantara.

Palestine L. of C. included the whole of the extraordinary Lines of Communication which ran from Kantara at first to El Arish, then to Gaza, subsequently to Jerusalem, and finally to Aleppo, probably one of the most extended and remarkable Lines of Communication ever constructed.

The peculiarity, however, of the Army Medical Service is that the Director-General of Medical Services is not a member of the Army Council. He is a subordinate officer to the Adjutant-General, and only has access to the Head of the Administration by courtesy ; and in like manner the D.M.S./E.E.F. is under the control of the D.A.G./E.E.F., and consequently usually approaches the Commander-in-Chief through that channel. Again, in like manner each of the A.D.sM.S. is under the control of the particular D.A.G. of the Command, and usually approaches the Commander of the District through him. The reasons for this arrangement and the desirability of altering it will be discussed later.

The Adjutant-General and his deputies deal largely with personnel, and are usually referred to as con-

stituting the "A" Branch of the Army. It then follows that there are two ways of communication between the D.M.S. and his A.D.sM.S. or between the Director-General of Medical Services in London and the D.M.S./E.E.F.: they can communicate direct (and frequently do) in purely medical matters, or the communication may reach them through the "A" branch. The variations in the relative number of communications received by the two channels bear a fairly close ratio to the strength of the occupant of the office of D.M.S. or D.A.G. as the case may be.

The District of an A.D.M.S., let us say the Delta District, has its head-quarters at Cairo, and under the administration of the A.D.M.S. of this district is placed a large number of most extensive base hospitals, convalescent depots, and the like, the medical arrangements of a large number of camps and garrison battalions distributed throughout the provinces; in other words, the welfare of many tens of thousands of troops. The Staff employed to effect this administration was 1 A.D.M.S. and 6 Medical Officers in the Head Office, including an A.D.M.S. Sanitary—that is, 7 medical officers who were removed altogether from clinical work. In addition there were a number of senior medical officers (S.M.O.s) in camps and barracks who combined clinical work with administrative work. The total number of medical officers employed in these three commands was:

Alexandria.—An A.D.M.S. and 3 assistants (apart from S.M.O.s).

Cairo.—An A.D.M.S. and 6 assistants (apart from S.M.O.s).

Palestine L. of C.—An A.D.M.S. and 3 assistants (apart from S.M.O.s).

G.H.Q.—A.D.M.S. and 3 assistants.

The general disposal of these medical officers was one A.D.M.S. Sanitary, one D.A.D.M.S. Administrative, and the others practically the same as the D.A.D.M.S. Administrative without the title. Five officers in Egypt were employed superintending hospital ships, hospital trains, and hospital supplies.

The Palestine L. of C. included not only Base Hospitals, but also Stationary Hospitals, Casualty Clearing Stations (C.C.S.s), and Field Ambulances. Beyond the C.C.S.s the Administrative Services were controlled by the D.D.M.S. of an Army Corps, also with an assistant, in addition to Divisional A.D.sM.S. also with assistants. It will, therefore, be seen that the number of medical officers withdrawn from clinical work and devoting themselves to entirely administrative work was considerable, and, what was more serious, some of these officers were men of considerable clinical ability.

The hospital administration was comparatively simple. The hospital was commanded in almost every instance by a lieutenant-colonel or colonel, who was a regular R.A.M.C. officer. He had a registrar, who in some instances was a major, and a medical and a surgical divisional officer with the official rank of major, who conducted the administration of the medical and surgical sides of the hospital, who was practically certain to be a regular R.A.M.C. officer if such was available, but in other cases these offices were filled by distinguished clinicians. In addition a surgical specialist was available in some cases; and as the years rolled by, an aurist, oculist, bacteriologist, X-ray specialist, and a dentist were gradually added to the Staff. The whole of these specialists were not present in every hospital, but some of them were present at every hospital, and all of them

in the District. In some cases the position of Commanding Officer was occupied by a major—almost invariably a regular R.A.M.C. officer or a Territorial. These positions were, in practice, rarely offered to clinicians, whatever their standing, or whatever their experience, whilst regular officers were available.

The non-commissioned officers and men in the first instance contained a fair sprinkling of trained men, but as the wastage of war proceeded the "A" Class men were transferred to the infantry and their positions filled by "B" Class men who required training. This substitution took place in 1917, and gave a great deal of trouble until it was completed. So difficult, however, did the conduct of affairs become in 1918 that some hundreds of the "A" Class men had to be withdrawn from the infantry and restored to the medical service. The difficulty was to obtain recognition of the fact that certain R.A.M.C. men belonged to highly skilled occupations and could not easily be replaced.

Such, then, was the mechanism as it appeared in Egypt, and any communication made by an officer passed in the ordinary way through his officer commanding to the A.D.M.S. and through him to the D.M.S. and ultimately, if it became necessary, to the Director-General in London.

So far as pay was concerned, it was made on the familiar scale laid down, but extra pay was available to those who commanded hospitals, to the divisional officers, and to some specialists, namely, oculists, pathologists, and surgical specialists. Beyond this the Army Authorities would not go; and no matter what extra work an aurist, for example, did, he was not officially a specialist, he received no extra pay, nor did he obtain any recognition or promotion.

It follows, therefore, that the position of a full colonel commanding a hospital of, say, 2,000 beds was a highly lucrative one, and the position of a captain occupying a divisional office was a superior one to that of a major who was a specialist.

Numerous cases of the kind were due, as I shall show later, to what I believe to be the convenient but rigid attitude adopted, for the system adopted throughout the R.A.M.C. is that promotion and increase of pay depend not on clinical merit, but on the administrative office held; that is to say, a clinician of the first order who was a captain could only secure promotion to the rank of major by obtaining a registrar's office or a divisional or some other post in which he would not be doing the same amount of clinical work, if any. There was, however, no means whatsoever of raising his rank or pay and continuing him in the work at which he had been successful.

In the service in Egypt, for the greater part of the time, there was what appeared to me to be a serious fault in the organization. Each D.M.S. or A.D.M.S. had associated with him a Staff Officer who was almost invariably much his junior. Owing to the mass of office work which centres in these administrative positions, neither the Chief nor the Staff Officer left the office for days together: they consequently did not come in contact with those who were doing the work, they were not aware of the atmosphere in different districts—in other words, they were imperfectly informed. As the line extended into Palestine these difficulties became more and more pronounced, and yet those conducting the work one or two hundred miles away occasionally received orders relating to their special work without any previous consultation whatsoever. As will be indicated

in the next chapter, the A.D.M.S. Force in Egypt met this difficulty in part by unofficially employing his Consultants as friendly inspectors. It seems to me, however, that there is only one possible way of building up a sound administration, namely, that each Administrative Head should have attached to him an officer of very nearly his own standard of rank, that either the Chief or his second should always be in the office, and also that either the Chief or his second should be constantly travelling. The tendency as one grows older is to become an office "wallah," but an office "wallah" is not usually a good administrator.

The system is not a little remarkable, since in the combatant branches of the service the sound policy was almost invariably followed. When friendly representations were made to administrative officers on the subject, the reply usually was that no senior officers were available to act as understudies. Personally, I should not have hesitated to have taken senior officers out of some other position, when so important an end was in sight.

Such, then, was the mechanism, and an admirable mechanism from some points of view, but it needs very little knowledge of the world to see that in such a hierarchy one obstructionist can create havoc, and can damp the enthusiasm of young energetic men and can force them to become time-servers or break their hearts. As one D.M.S., a man of great ability and moral worth, said to me, it is possible in the service for a senior to completely break the spirit of a junior officer without infringing a single rule. I have often thought myself that had I as a young man joined the service, I should either have had a conflict and, like Cassio, been "removed" at some period of my career, or I should have

had intellectual enthusiasms more or less completely blotted out.

It is the purpose of this section of the work to indicate how this organic mechanism can be retained with its many advantages and shorn completely of its soul-killing tendencies.

CHAPTER XIV

CONSULTANTS AND PRESIDENTS OF STANDING MEDICAL BOARDS

Consultants.—It seems that before the war oculists, aurists, and other specialists were not much in demand in the R.A.M.C., because in general those admitted to the service of the Army were not supposed to have special defects, and if they developed them during service they were discharged from the Army. It was, in fact, an eclectic army, composed for the most part of fit men. At the same time a scrutiny of the regulations of enlistment will probably show that these conditions were not observed at all strictly, and that some of the standards were little short of ridiculous. It has, for example, fallen to the lot of some of those who have been at work in Egypt to find that the vision of generals was of such a nature that they could not have properly gained admission had the standards been observed, and the inference may be that the standards were used in a more or less elastic manner, according to the nature of the candidate. Furthermore if the strict enforcement of such standards was adopted, it must have made recruiting difficult, as it must have excluded a large number of desirable people.

The matter is mentioned here with the object of drawing attention to the fact that the R.A.M.C. regulations, as a whole, were based on the supposition that the officers were dealing with fit men, and that conse-

quently oculists, aurists, dentists, and other specialists were not requisite to any great extent. This, however, has been a national war in which every human being who could be in the service was required, and consequently the standards of physical efficiency have been revised from time to time. They had not, however, in my judgment been revised with sufficient thoroughness until the matter was taken in hand in Egypt. For a time in Egypt, so far as visual standards were concerned, local arrangements provided for standards far below those fixed by the Army standards, but which were nevertheless in the judgment of the Consulting Oculist and the D.M.S. adequate, and indeed proved so in practice. Similarly, the Consulting Aurist retained in Egypt the whole of the men suffering from chronic otorrhœa and their retention proved thoroughly satisfactory. Had all men whose vision was below the recruiting standard, and had all men suffering from chronic otorrhœa been withdrawn from the fighting line, the position of the General Officer Commanding would have been serious, as the number, as far as could be estimated, was many thousands. In consequence of the legacies from the R.A.M.C. Peace Establishment, this problem of adjustment of old standards to new conditions was incessant, and it was not completed when the war terminated.

When war broke out there were no Consultants, but during 1915 several Consulting Surgeons passed in and out of Egypt, one Consulting Surgeon remained, and I myself was appointed Consulting Oculist and incidentally Aurist to the Force in Egypt. When the military organization settled down after the evacuation of the Dardanelles, and with the departure of some of the troops for France, the position was as follows :

There was a Consulting Surgeon and a Consulting Physician in Alexandria, a Consulting Surgeon in Cairo, there was a Consulting Oculist for the E.E.F., and also a Consulting Aurist for the E.E.F., but beyond this there were no Consultants. Their powers were defined in terms of a War Office memorandum, and were powers of such a nature that had they been acted upon the service would have been in an uproar in a week; but being sensible men, and having the confidence of the D.M.S., they never attempted to use them. During 1916 and 1917 other appointments were made. A Consulting Dentist to the E.E.F. was appointed, whose task was indeed a formidable and valuable one; a Consulting Surgeon was appointed to the Delta District, and a Consulting Neurologist to Egypt.

During 1917 and 1918 two more Consulting Physicians were appointed, one for the Delta District and one for the Palestine L. of C. The appointment for the Delta District was made just before the war ceased, so that with the exception of a few weeks in 1917, during which a Consulting Physician—Delta District—held office, the Delta District was without the services of a Consulting Physician during the whole of the war.

In 1918 for the first time, the duties and functions of these officers were defined. The A.D.M.S. of the Force in Egypt met them and obtained a definition of their functions. He then called them together once a week, placing them all on the same footing. At these weekly conferences each member was invited to report on any matter relating to his work he thought fit, whether administrative or purely clinical, and the matter was discussed with the A.D.M.S. in the

presence of the other Consultants. The practice was continued by other A.D.sM.S. of the Force in Egypt, and the force of Consultants gradually developed into a body of friendly inspectors, who acted to the A.D.M.S. as a Military Medical Intelligence Department. Presently hard-working medical officers discovered that the Consultants as a body were there to help them, brought matters under their notice, with the result that friendly and rapid adjustment of their difficulties was frequently effected. This most successful system, begun late in the war, was brought under the notice, in some way, of the Commander-in-Chief, who inaugurated a similar system as regards the D.M.S. At first these meetings were limited to surgeons and physicians, the other specialists being excluded. As a result of this action a most invidious distinction was made between the different branches of medicine, but, as pointed out on page 150, rectification was subsequently effected.

The War Office ruled in effect at the end of the war that Consulting Physicians and Surgeons should hold the rank of colonel, that the Consulting Oculist and Aurist, who are also Presidents of Boards, should hold the rank of lieutenant-colonel, that the Consulting Neurologist should be a major, and that the Consulting Dentist should be a major or a captain. This curious classification of ranks and this exclusion of specialists from discussions indicates the survival of what always appears to me to be an archaic belief. I have never been connected with a medical school or university in which the view was not taken that all divisions of medical knowledge were equal in importance, and on scientific grounds any other attitude would be difficult to justify. If, however, in the Army it is necessary to take the

view that the requirements of the soldier came first, and that discrimination should be made, then it seems to me that the Consulting Dentist should come first, as within the territory of his administration there were nearly seventy dentists whose services were absolutely necessary for the supply of soldiers; next comes the Consulting Oculist and Aurist; whilst at the bottom of the list I should place the Consulting Physicians and Surgeons, who are not so indispensable, since every medical officer knows something about medicine and surgery. It is true, however, that subsequently this anomaly was corrected so far as meetings were concerned, and all Consultants were placed on the same footing as regards meetings, but the anomalies in rank continued.

I know of few instances which throw a more vivid sidelight on the mode of thought of those who direct the organization of the R.A.M.C. than that just narrated.

It should be understood that Consultants have no administrative powers in theory, and they never issue a direct order even in clinical matters, but they advise the A.D.M.S. or D.M.S. as the case may be, and he takes action or not as he thinks fit after discussion. When it was possible to deal with a D.M.S. or with A.D.sM.S. who were willing to meet the Consultants and willing to be advised, the system worked well; but in the few cases in which these officers did not wish to meet the Consultants or to be advised, in which they, so to speak, regarded themselves as omniscient, the system worked very badly, and these officers felt as if they were simply window-dressers kept for the purpose of impressing the public. Yet as the years rolled by, complaints in Parliament and the like caused reference

to be made to Egypt, the answers to which required special knowledge which not even an omniscient D.M.S. possessed. It was then that the political value of these appointments became apparent.

The position of these Consultants throws a flood of light on the rigidity of the service. They are not provided for in any regulation, they did not exist in pre-war days, and consequently there was no establishment in which they appeared. They had little clerical assistance, there was a chronic difficulty with motor-cars and conveniences, and their travelling allowance was on the same scale as that of any other officer, notwithstanding the fact that their expenses were far heavier.

Summarizing, then, it will be understood that at the end of the war the following Consultants were attached to the Staff of the D.M.S./E.E.F. :

3 Consulting Physicians;
3 Consulting Surgeons
(Who were attached respectively to Alexandria, the Delta District, and Palestine Commands);
1 Consulting Oculist;
1 Consulting Aurist;
1 Consulting Dentist;
1 Consulting Neurologist; and
1 X-ray Specialist.

I think it would have been wiser to have appointed one Chief Consulting Physician and one Chief Consulting Surgeon to advise the D.M.S., and to have appointed other surgical and medical Consultants to the areas referred to. One officer can direct, three cannot!

Presidents of Boards.—Towards the end of the war, another office became of vast importance, the office of President of the Standing Medical Board. This work was begun early in 1917, when it became evident that the man-power of the empire was becoming exhausted, and that what there was had to be used to the best advantage. I was appointed President of the Standing Medical Boards in the E.E.F., excepting Alexandria, which some months later was placed in charge of the Consulting Oculist. In these capacities we had to work out a proper business system, to establish proper physical standards, and, by being as human as possible, to make an unpopular and difficult system work. Ultimately, at the end of 1917 when the system was in working order, it was divided into three and then into four parts, and Presidents were appointed for the Standing Medical Boards, Palestine L. of C., the Canal Zone, the Alexandria District, and the Delta District respectively.

Theoretically these Presidents did not exist, as their functions had not been contemplated in times of peace; and consequently difficulties arose concerning clerical assistance, typewriters, travelling expenses, and promotions. So it came about that I personally had to employ a civilian stenographer, to purchase my own typewriter, and to a large extent to pay my own travelling expenses. I do not grudge these things personally—either the work had to be done in this way or not at all—but I quote the instance as illustrating the inflexibility of the service.

The attitude of the R.A.M.C. officer brought up in the old school was one of courteous and sometimes even genial toleration for an incubus in the form of a Consultant or a President of Boards. Those, however, who

were administering the service presently found out their great value, particularly as War Office inquiries began to appear in Egypt which required precise and accurate answers, and towards the end of the war the Standing Medical Board was firmly established in spite of attacks. Before, however, disposing of the subject for the time being, it may be worth while to point out the extreme difficulty men accustomed to civil administration find in understanding any delay in rapidly grasping these altered conditions and in dealing with such matters in an ordered and sensible way.

The older type of R.A.M.C. officer who commanded a hospital had difficulty in understanding that with one President for many Boards uniform standards must make their appearance, and that the knowledge gained by the difficulties of one Board was carried on to the next. He further did not appreciate the fact that an order relating to classification or invaliding conveyed by the D.M.S. to the President of a Board was easily carried out, whilst an order sent to multiple Boards was more liable to end in confusion. Furthermore, an officer of the old type commanding a hospital found it difficult to contemplate any system by which he was not absolutely supreme in all matters within his own hospital, and he consequently viewed the Consultants and Presidents of Boards as innovations who might be personally pleasant enough, but who did not belong to the scheme of affairs in which he had been brought up.

CHAPTER XV

EDUCATION, CHANGES OF PERSONNEL, AND PROMOTION

Education of Medical Officers

In my judgment, one of the greatest failures of the service has been the failure to train newly arrived medical officers. As junior medical officers made their appearance in Egypt, they were posted to various positions and there allowed to pick up what information they could. It might be they were sent to a Field Ambulance, they might have been posted to a Battalion, they might be sent to a Base Hospital; but of the general organization of the medical service, of the reason for the existence of the various returns, they were entirely ignorant, and being so became resentful of the amount of clerical work imposed on them. Had they been taken into confidence, and had they been invited to round-table discussions with senior officers, they would have learned more rapidly and their enthusiasm would have been preserved; but though repeated informal recommendations were made by the Consultants that this should be done, it never was done to any considerable extent. The nearest approach to it was a series of clinical meetings held in Cairo and Alexandria during the winter of 1916, and presided over in many instances by the D.M.S. of the time, whose genial attitude did much to help.

The usual arrangement in Egypt was that there were nine officers in a Field Ambulance, whereas in the

judgment of nearly all concerned three medical officers are quite sufficient. Nearly the whole of the work of a Field Ambulance could be done by sergeant-majors. The explanation given was that the surplus were required for regimental reinforcements in the event of casualties, an arrangement the soundness of which did not commend itself to the judgment of most of the medical officers. Nothing seems more certain than the importance of the work of a battalion medical officer, not because his work is purely medical, but it is requisite that he should possess sound medical knowledge, with excellent medical judgment, and that few young men possess. The general verdict was that the battalion medical officer should be a medical man who has been in practice for some time, and about thirty to thirty-five years of age, that young men should be employed in the Field Ambulances and the older men farther back. Yet newly joined medical officers were thrown now into this and then into that position without preparation or adequate training of the kind, and the result, as might have been expected, was a great deal of what is known popularly as "grouse."

Something, however, must be said about the civilian medical officer. The ordinary civilian doctor entering the Army, without any special training or instruction, was often a source of very great trouble, not only to the regular R.A.M.C. officer, but also to the temporary officer who had acquired a knowledge of military ways. The training of the average medical man is intense but narrow; all his energies are concentrated on one problem, doing the best for the sick man professionally. He consequently speculates on remote risks his patient may undergo, and warns him from doing this, and that. His job is to conserve the comfort and the

well-being of the man who is employing him, and with obligation to the State he is not concerned. In the Army, on the other hand, everything must be done for the good of the service. It is true that the comfort and well-being of the soldier is studied, and studied thoroughly, but always with a specific end in view. The actual clinical proceedings differ very greatly in accordance with the spirit in which they are approached, and in common with many other officers I arrived at the definite conclusion that I would not allow a purely civilian doctor to have anything to do with the soldier so long as he was in the service. The civilian doctor is almost certain to desoldierize him by his policy of advising the avoidance of all risks, and by his adoption of what are really obsolete physical standards. When the soldier is discharged from the Army and requires medical and surgical attention, then the civilian doctor may be given a perfectly free hand; but I voice the conviction of many temporary officers, that they would not have permitted any medical practitioner to sit on any Medical Board if he had not actually served in the field himself, because in the majority of cases he does not fully understand the problem, and he does much harm with the best of intentions.

Many of the difficulties just alluded to are produced by what was well called the theory of omniscience. Once an administrator takes up the comfortable attitude that if an officer is a medical practitioner he can do any work that comes before him, and that he is dealing with medical officers as interchangeable units, then it is certain trouble will ensue in many directions; and if an administrator imagines that he is omniscient and capable of judging details in all branches of

knowledge, then he is certain to get into difficulty, at all events from the scientific point of view. It seemed to those of us concerned that the proper course would have been to have taken a careful census of all the medical officers in the field, and to have made all possible inquiries from Consultants and senior officers in the field respecting their capacities. It would thus have been possible to place them in the positions in which their services would be most valuable.

Change of Personnel

During the four years I have served in Egypt, I found myself under the control of no less than ten Directors of Medical Services, eight of them direct, and two indirect—that is to say, one was a subordinate D.M.S. and the other principal D.M.S. It is true that one of them only held office for a few days, and another only for a few weeks, but the passage of chiefs reminded one of the procession of ghosts in *Macbeth*, and the changes in subordinate commands were on a similar scale. Now everyone is aware of the difficulty in war-time of securing continuity as in times of peace, but these constant changes served no good purpose. Egypt was saved in 1915 from a disaster similar to that which took place in Mesopotamia, and all the peculiar difficulties incidental to the country were met and surmounted, hospitals being built up in a certain fashion. After the evacuation of the Dardanelles, there was a reduction in the size and strength of the hospitals, and from that time to the end of the war the hospital accommodation in Egypt resembled the movements of an accordion. Came there a slack period, as there did almost every winter, the tendency was to shut up the hospitals; came there a heavy season, the tendency was

the reverse; and owing to these constant changes, at the end of the war the position was distinctly dangerous. The number of changes of subordinate commands in Egypt must have been very large, and apparently larger than was absolutely necessary. But something even more serious developed as time went on.

The D.M.S. centralized authority in his own office. He apparently believed that the forward area was more important than the base, whereas I think most officers would be of the opinion that you might as well compare the importance of the arm and leg of a human being —he needs both. As a result, he (or someone under his authority) began to move medical officers from Base and Stationary Hospitals at the Base to forward areas, without consulting the A.D.sM.S. of the Districts or the Officer Commanding the Hospital; and thus specialists were taken from their work and were given work that specialists ought not to do, and work at the Base was sometimes thrown into confusion.

One of the most notable instances of the confusion which can be caused in this way is furnished by the following incident.

An Aural Specialist had just been placed in charge of a very large clinic, a clinic which was serving the needs of a large Base Hospital, and of a soldiers' camp. He was appointed for the purpose of relieving the aurist who was absent on leave in England. The arrangement for his appointment was made by the D.M.S. after consultation with me. I left for another city leaving everything in order. Some two or three weeks later I received a pathetic letter from this officer to say that he had been suddenly sent up the line to a Field Ambulance or C.C.S. (I do not remember which), and would I let him know whether he had done any-

thing wrong. Meanwhile the work at the Base Hospital was in difficulties.

The A.D.M.S. of the District thought that I must have advised the D.M.S. to take this step, the D.M.S. personally was unaware how it happened, and the Officer Commanding the Hospital did not understand what had occurred; if the specialist had not written the personal letter to me I should have been entirely unaware of the confusion which had followed. If on the other hand the order had reached the A.D.M.S. District, and he had been asked to send someone to the Casualty Clearing Station or Field Ambulance as the case may be, he would naturally have consulted me before damaging what he knew to be an indispensable clinic, and some reasonable adjustment of the difficulty would have been found.

On representation being made of the impossibility of conducting business in this way, an alternative being requisite, an A.D.M.S. suggested that if so many medical officers of a certain character were required in forward areas, and the fact were communicated to him, he would send them on and do the work with the minimum of staff. The reply was that the worst men were usually sent forward, and the practice to a large extent continued, mitigated, however, by the policy adopted of leaving specialists alone. To me it was a sad confession of the inefficiency of the administration. If it was true that Officers Commanding Hospitals sent away their worst men, it should have been a comparatively simple matter to deal with them and rectify this evil, but to cause wholesale disturbance instead of dealing with the evil seemed to most officers to be a mechanical way of endeavouring to solve a human problem.

Promotion

In the R.A.M.C. there was no such thing as promotion for service in the class in which an officer was appointed; such has been the experience of the war. If a captain was made a Consulting Surgeon, as was the case, he became a lieutenant-colonel, and then a colonel. If a captain was made a Consulting Dentist, as was the case, he remained a captain, because the position of Consulting Dentist did not carry any definite rank. If a captain in a hospital did magnificent clinical work, he could not obtain higher rank except by becoming Registrar or Divisional Officer—that is to say, by giving up part of his clinical work and taking up administrative work; in other words, excellence in a special department of knowledge could only be recognized by asking him to do something for which he might not be fit, mentally and by training.

The reason for this system will be readily understood. It avoids intellectual and moral effort. It is possible to promote a man in this way irrespective of the value of his special services in his new post and in a way that cannot be challenged—that is, an excellent official reason can be given for it. If, on the other hand, it became necessary to promote a man for his own knowledge and lift him above the men around him, it would require careful adjudication and plenty of moral fibre to answer the criticisms of the disappointed; and yet, as I shall show later on, I know of a great service in which this is done, and done successfully. To me, the faulty mainspring of the R.A.M.C. lies in the moral abasement indicated by this attitude.

As a matter of fact, when a R.A.M.C. officer ceases to be a major and becomes a lieutenant-colonel, he passes

away from clinical work altogether and becomes an administrator. It does not matter what his inclinations may be, or what his ability may be, he must either become an administrator or lose his chance of reward; and the result is that the majority of men, seeing that promotion lies one way only, begin to get out of touch with clinical work, and presently do not quite understand the drift of modern thought. It was largely in consequence of this attitude that the service was so long in properly defining the positions of Consultants and Presidents of Boards. Accustomed to regard the Officer Commanding as omniscient, they failed to realize that in medicine to-day no human being—scarcely even a god—could hope to be omniscient, but he can hope to possess such an insight into, and such a knowledge of, scientific thought that he knows exactly where to turn for helpful and intelligent advice.

The Sanitary Department of the R.A.M.C., or, as I should prefer to have it called, the Prophylactic Department, is in my opinion one of the most important departments, but it is the Cinderella of the service. He who takes it may get the satisfaction of doing splendid work, but he will receive neither the promotion nor the rewards which are given to the administrative service. The prevention of disease is never dramatic, people fail to visualize that which has not occurred, and the A.D.M.S. Sanitary in the service at present occupies an indifferent third position (and the clinical element may be placed as a bad second). A noteworthy case existed in Egypt where a Professor of Sanitary Science ultimately at his own wish was placed in command of a Field Ambulance for reasons that are indicated in the foregoing.

CHAPTER XVI

SUMMARY

In the foregoing sketch I have endeavoured to show some of the sources of strength and weakness of the Army Medical Administration, and I propose in this chapter to indicate what I believe to be the changes necessary in order to conserve that which is sound and eliminate that which is hurtful.

The problem which lies before us is much more simple than any problem that has been presented to the nation before, since thousands of civilian medical men have passed through the R.A.M.C., and have become intimately acquainted with its best and its worst features. The administration is no longer a mystery to them, and its strength and weakness are an open book. They understand perfectly that, whilst a good administrator in the R.A.M.C. would probably be a good administrator elsewhere, yet compared with the difficulties of civilian administration, administration in the Army Medical Service is fairly easy, since it is in the main administration by regulation. They also see how easily men fall away from ideals, and become the servant of a machine, regarding these regulations as sacrosanct, instead of regarding them as a convenient record of the practice that has usually been found to be serviceable, which may be modified at times, and in emergency must be broken. Never has there been a service in which

the theory of legal fiction is more obvious. The King's Regulations may not be broken, but in practice in war-time they have to be broken, though undoubtedly they are observed as far as it is possible to observe them. The process of amendment is so slow and difficult, owing to the centralization of the machine in London, that it is requisite at times that someone should have the courage to do what is right.

The "Office Wallah" Method

The first and fundamental weakness in the administration is to me the tendency to become an "office wallah" and to endeavour to manage a large body of highly individualistic, capable men by writing letters to them; letters written often by a man who knows less respecting some special subject than does the recipient. The first and obvious change in principle is that superiors should fully and in conference discuss important items with their subordinates, retaining if necessary the right to take action if they think fit. They should endeavour to come to an agreement with those officers who are to carry out the policy agreed to, and the letter should be written, as in civil life, as embodying the spirit of the agreement reached. I never could have imagined, had I not been in the service, that I should receive a letter written at a distance of 200 miles, giving me instructions regarding expert action in my own department without any previous consultation of any description whatever. As a matter of fact had I obeyed the order, administration would have become difficult. I need hardly say that I represented with proper respect the deadlock which faced us, and managed to obtain some amendment. Experience of the kind was not very frequent,

and all the temporary officers made up their minds during the term of the war to do their best to try to make the machine work somehow or someway, but most of them felt that when the war was over the time would come to try to introduce a more reasonable system, and one more in accord with the scientific spirit of the time.

In my judgment, no administration will be sound in which every administrative officer is not provided with an understudy of nearly the same rank as himself, so that one or the other may be constantly travelling throughout the command. When it is recollected that in the E.E.F. the distance from one end of the command to the other reached 700 miles (approx.), the futility of the "office wallah" method of administration will become obvious.

Proper Rank for Clinicians

A fundamental fault of the R.A.M.C. organization is that in its higher branches its officers cease to be medical men, and do not become soldiers; they become what are called administrators.

When an officer is promoted beyond the rank of major and becomes a lieutenant-colonel, his work becomes purely administrative; and unless his character and mental constitution are remarkable, sooner or later he is apt to lose touch, first with the practice of medicine, and then with scientific interest in medicine. He may become a very good administrator, though, as I have previously mentioned, administrators do not require any extraordinary ability. There is surely another way of dealing with the matter. In my opinion there should be three avenues to promotion:

(*a*) As at present through administrative work, for those whose inclinations take them in that direction,

but (*b*) it should always be possible to rise by clinical work alone, and to reach in time of peace as in time of war a position of Consultant in some branch of knowledge with a rank equal, or nearly equal, to that of the administrator. (*c*) It should also be possible, by devoting life's energies to preventive medicine, to rise to a similar position with similar rank in that department of knowledge.

If, then, such a principle were adopted, a large command in time of peace would consist of: a Director of Medical Services, with a Staff consisting of a Consulting Physician, Consulting Surgeon, Consulting Oculist and Aurist, Consulting Dentist, Consulting Preventive or Prophylactic officer, or Sanitarian. He would consult these officers in all matters relating to their special functions, and if he found it necessary to over-ride their advice, would minute his reasons for doing so. As a matter of fact such a Staff sitting together as a Council would rarely end in disagreement. The practical difficulty that would lie in the way of clinical development of such men is the lack of opportunities of practice when dealing with a fairly healthy Army.

Civilian Advisory Boards

There is something to be said for this argument, which has, however, been long since met in Germany, where the medical officer of the Army is attached for considerable periods to civilian hospitals, laboratories, and the like. In order to secure the necessary nexus it is desirable that not only in the Chief Command, but in all Subordinate Commands a small civilian medical committee, partly nominated by the Army and partly nominated by the local Medical Association itself, should be associated with the directors as an advisory

body. Whether this advisory committee should be paid or not is a matter for discussion. Personally, I should prefer to see it a body of honorary members, and the reward made one of honour only. There are many distinguished members of the profession who would gladly give their services in such a national concern. This method has always appeared to me to make such committees much more effective, and such at all events has been my own personal experience. I have served on many Government committees, I have never received any Government fee or allowance, and I have felt the independent atmosphere has been enhanced by the fact that I was under no obligation to anyone in the service.

Promotion

Let us, then, suppose that the organization is as I have sketched it. How is promotion to be effected? And there we reach the crux of the problem. Promotion in Egypt has not been effected at all except by appointment to administrative positions which carried rank; in other words, by moving men from something they could do, in some cases to do something for which they were not suitable, in order to give them rank, and all promotions have been effected on the *ipse dixit* of one man. This system appears to me to be absolutely wrong. Sooner or later a subordinate may offend the Chief, or he may come in contact with the Chief, the two men being mutually incompatible, and trouble must ensue unless the Chief is a man of extraordinary tact and judgment. In a Government Department in Australia a system has been evolved which goes far towards meeting this difficulty of providing a stimulus of just promotions. Promotions are effected by a Board

of three; one member is appointed by the Secretary of State (*i.e.* Minister), one by the Public Service Commissioner, and one by the class from which members are to be promoted. The record of the officer is examined, not only with respect to the work he has done in the service, but with respect to the part he has played in the life of the community; in other words, a broad survey of his character is made. If this method of promotion were adopted, and if the changes indicated above were made, I can imagine an Army Medical Service which would attract some of the finest brain and character in the country and from which work of the first order might be expected. The necessary flexibility would be obtained, the closer association of the civilian and military elements would be conserved, and we should have a mobile service which responded more or less accurately to every advance in human knowledge.

Should the A.M.S. be under the "A" Branch?

It will be remembered that the Medical Service is placed under the control of the Adjutant-General and his deputies throughout the service. An attempt was made after the South African War to abolish this arrangement and to place the Director-General and the Directors of Medical Services on the same footing as the Adjutant-General or the Quartermaster-General; that is, the Director-General would become a member of the Army Council, and the Directors of Medical Services would have direct access to the Commander-in-Chief. The proposal, however, was not adopted, notwithstanding the advocacy of Sir Alfred Keogh.

I have now had opportunities for four years of watching the system, and I feel less positive than I did of

the desirability of effecting the change. The real difficulty, which is rarely, if ever, expressed in writing, is that the education of the ordinary medical man requires to be broader if he is to take up such a position. Whilst amongst the Directors of Medical Services there have been many of broad outlook, capable of holding their own in association with other men, there have been a sufficient number of men who did not possess the qualities to warrant making so radical a change. The circumstances of the war have deepened the conviction formed by me in civil life that medical education must be modified in some way so as to give medical men a wider outlook and a better conception of their relationship to society, a theme on which I heard the President of the United States speak with great vigour in 1912.

Personally I think it would be better that the Director-General should be a member of the Army Council, and that the Directors of Medical Services should have direct access to the Commander-in-Chief; but if such a step be taken, great care will have to be exercised respecting the appointments. It will not be sufficient to appoint an officer who is a good medical practitioner, he must be a cultivated man of science as well.

Medical Officers should do Medical Work

On minor matters, such as the misapplication of the abilities of medical men by allotting clerical work and very ordinary administrative duties to them, Lieut. Deane and I have already written at some length in *The Australian Army Medical Corps in Egypt*. There is no doubt that many of the functions discharged in the Army by the medical officer could be better discharged by a sergeant-major, or a lieutenant-quartermaster.

The more the expert knowledge of medical men is utilised and the less they are employed for work that other people can do, the more efficient the service is likely to be.

Education

Reference has been made in the course of this work to the necessity for providing instruction for the newly joined medical officer. The matter is of very great importance. For example, much trouble and expense were caused by the fact that medical officers, in passing men down the line, either would or could not pass on clinical information with them. The result was that when the patients arrived at the base or at the halting place, all the work had to be done again. There were instances of two or even three X-ray photographs being taken of the same physical condition for the same purpose, simply because information was not passed on through the proper channel. If, however, no senior officer took the trouble to explain to the junior officer what this channel was, and why it was important that this information should be passed on, there was little wonder that there was some neglect. Probably the hardest part of administration in the Army is securing the rapid passage through the proper channels of the necessary clinical information.

The Nature of Military Medical Work

The public generally pictures the Army Medical Service as a collection of enthusiastic medical men doing their best for sick and wounded soldiers. As far as I can hazard a guess, this really represents one-third of their work. It is of course a necessary part of their

work, and from my experience it is done very thoroughly and conscientiously. But the military medical problem differs wholly from the civil medical problem, and quite another third of the military activities is, or should be, devoted to the prevention of disease, whilst the remaining third resolves itself into attempts to properly dispose of the sick or wounded soldier, to decide when he is fit to work, where he is fit to work, and what work can be given him to do. The medical practitioner in civil life is not concerned at all seriously with this principle, or with the problem of the prevention of disease in the main. At conferences of Consultants held in Egypt, some of the more newly appointed Consultants took the view that they were in Egypt for clinical purposes only, and that they had nothing to do with administration, yet during the discussion I think it is a fair thing to say that very rarely did one of them utter a dozen sentences without trenching on the province of administration. Medical administration and clinical medicine are intimately associated, because treatment includes the proper placing and disposition of the sick man. If it has taken those of us who have been in the service many months or years to become thoroughly acquainted with these elementary principles, what chance has the newly joined medical officer of understanding them unless there is some systematic instruction in the matter? Furthermore, orders, amendments of orders, and circulars are issued in profusion. One of the ablest medical administrators I have ever met told me he was satisfied if he could get some attention paid by medical officers to the third issue of the same order. Civilian medical practitioners are not in the habit of taking orders. They frequently do not read them, or reading them do not grasp them, and in my judg-

ment the position could have been improved by two methods :

1st. The method of conferences, and

2nd. A systematic and periodical codification of orders, their publication in printed form, and their issue to every medical officer in the Army. Their number is so great and the complications are so bewildering that is almost impossible to carry them in memory.

Redress of Grievances

A proper method of redress should be devised for an officer who finds himself aggrieved by action taken in the service. Now just as promotion should not be dependent on the *ipse dixit* of one man, in like manner serious differences should not be left to the unchecked judgment of one man, and there should be a Board of Reference for serious complaints. The position is remarkable. From a sense of loyalty few officers care to complain about a senior. If they do complain it is more than likely that the senior will get into trouble if he is in the wrong, but it is probable that the junior will be punished whether the senior is in the right or not; in fact, the old Japanese principle is applied, though it is not supposed to be. In the tales of Old Japan it is narrated that a village headman whose village was being maltreated by their immediate lord, appealed to the overlord in the Feudal Hierarchy. The proceeding was quite constitutional and recognized. Complaint having been made, the overlord was compelled to redress the grievance, but he who complained forfeited his life to his immediate lord, unless pardoned as an act of grace.

It seems to me that a good deal of this principle holds good in the R.A.M.C., and it is not right that it should

How can Reform be effected?

By what means, then, can such changes be effected? I see nothing for it but a properly constituted Royal Commission, with power to call for evidence and to protect those who give evidence, so that the speaking may be plain. But the Commission should be carefully appointed, and so far as the medical personnel on that Commission are concerned, I should recommend certain limitations and reservations. I should suggest that a certain number of the seats in the Commission were filled not by Government nominees, but by officers elected by those medical officers who had served abroad, in Egypt, Mesopotamia, and in East Africa, for substantial periods of time. These medical practitioners have been abroad, away from their families and practices, communication with their friends has been difficult, and they alone know exactly where the administrative shoe pinches.

I hope from the foregoing chapters I have given clear indication of my appreciation of the essential soundness of the work done by the R.A.M.C. during the war, and at the same time of its limitations. I believe that all that is sound in it can be retained and by the adoption of the changes indicated it can be made a flexible, mobile institution, capable of greatness, capable indeed of leading the nation not only in matters relating to military science, but also in civil medicine and surgery.

Is it not obvious that the criticisms amount to the statement that the service shows much individual excellence with defective organization?—a criticism which applies more or less to the various institutions of the Empire. Anglo-Saxons possess the faults of

their qualities and tend to become intellectual anarchists. The day has passed, however, when individuals acting as such can do great things, and the future lies to the intelligent who can combine loyally in team work.

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CHAPTER XVII

CONCLUSION

In the foregoing chapters the organization of the R.A.M.C. has been sketched. The writer's personal experience of phases of its work has been detailed, and he has endeavoured to indicate its strength and with equal clarity its serious shortcomings. A fitting conclusion may be reached in the endeavour to indicate the principles on which inquiry should properly be made. Let us ask ourselves, What is the national purpose of having a Royal Army Medical Corps ?

The obvious and superficial answer is that the nation requires a permanent Army and consequently needs a medical service to care for the health of the soldier in peace and war. The experience of wars shows us that the R.A.M.C. is quite inadequate to deal with this requisite in time of war without calling in the aid of the civil medical service, since in its ranks it contains neither the number of officers nor the special knowledge necessary for the satisfactory handling of even a moderate military undertaking. A Royal Commission would therefore inquire whether the arrangements necessary for calling in this civilian aid were adequate, and whether the brains and ability so called in were disposed to the best advantage.

But it is obvious that further pertinent questions must at once obtrude themselves. Wars are infrequent, and for years this body of R.A.M.C. officers existed

under peace conditions and is apparently not overworked. Have proper attempts been made to utilize fully the services of the able men in the service for the benefit of the nation? Has research been encouraged and duly rewarded by promotion which did not involve cessation of research? Has the study and practice of preventive medicine been encouraged by suitable and similar promotions? Has clinical excellence been regarded as a reason for promotion plus retention of clinical work?

If these and similar activities have not been encouraged, may not the nation well ask whether it is getting a proper return for its expenditure? Should not the R.A.M.C. be employed for such national purposes, and make its mark felt in all these spheres of activity? Have these aspects of the problem been clearly and publicly presented?

From the Crimean War to the Boer War and thence to 1914 the R.A.M.C. has lived in profound peace. What has been the output for the benefit of the nation, and if the result be disappointing whose fault is it? I am well aware that after such inquiries as those effected by the Mesopotamian and Dardanelles Commissions there is always a public tendency to try to fix the responsibility on some one officer. Now it is true there are in all services inefficient men, but in general no one wishes to be a failure, and most men do their best. Is not the truth largely that the nation by its indifference and penuriousness forces the development of a bad system in the meshes of which even an able man is helpless? If this prove to be the case, as I feel sure it will, why not concentrate some critical attention on this system, overhaul it root and branch, and honestly face proper reconstruction?

If this view be entertained, the following features of the system amongst others will require special attention:

(1) Should Directors of Services be regarded as omniscient, or should they require Staffs of special advisers?

(2) Should the medical officers of the same rank be regarded as interchangeable, and of equal value, or should special knowledge and ability be labelled?

(3) Should promotion for clinical excellence, for clinical ability or distinction in preventive medicine, be obtainable only by cessation in part or *in toto* of the special work in which excellence has been demonstrated—in other words, by taking to administration?

(4) Should promotion be effected on the recommendation of one man, or should the value of all officers be carefully and periodically reviewed by a Board on which civilians are represented?

(5) Should not every command be associated with a Civilian Medical Board, since whenever war breaks out civilian medical men are required to enable the R.A.M.C. to do its work?

(6) Is it desirable that the "office wallah" type of administration should be further encouraged?

(7) What status and functions should be assigned to Consultants, Specialists, and Presidents of Boards?

(8) Should medical officers be required normally to perform non-medical and clerical duties?

(9) Should some system of military medical education be provided for newly joined civilian officers, and should not the system of conferences be widely extended?

(10) Should not a proper system and tribunal be instituted for the redress of supposed injustice, or is the mediæval Japanese system to be endowed with immortality ?

The above list is not, and is not intended to be, complete, but is furnished as an indication of the questions which every thoughtful medical officer, regular or temporary, is likely to put, and to which the nation may rightly require plain answers.

A scrutiny of these questions will reduce their number in substance, so that they may be put as follows :

For what national purpose does the R.A.M.C. exist ? How is it governed ? and what type of medical service within it is rewarded ?

The problem discussed is very serious, since on its satisfactory solution so much depends which is vital to the nation. The answers of a Royal Commission may be far from those which I have indicated, but whether that prove to be so or not it is important that the issue should not be evaded or camouflaged; in other words, that an honest answer should be given to plain inquiry.

Such inquiry depends on the action of those eminent medical men who have unostentatiously made huge sacrifices during the war, who have been very sensible of the defects described, but whose loyalty has caused them to make the best of it. They are returning to attenuated or non-existent practices, often with no thanks or recognition beyond the sense of duty done, and they are at the least entitled to ask that proper weight be given to such representations as they may make.

They may well ask that their reward shall be a betterment of the service in the interest of the nation, in the interest of its officers, and indeed in the interest of the science of medicine.

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